



Occupational Medicine

5802724 - Occupational Medicine Request for Services - Norwich

Company Name:
Company Contact:
Company Phone:

Express Care Walk-In
UHS Occupational Medicine Norwich
54 E. Main Street
Norwich, NY 13815

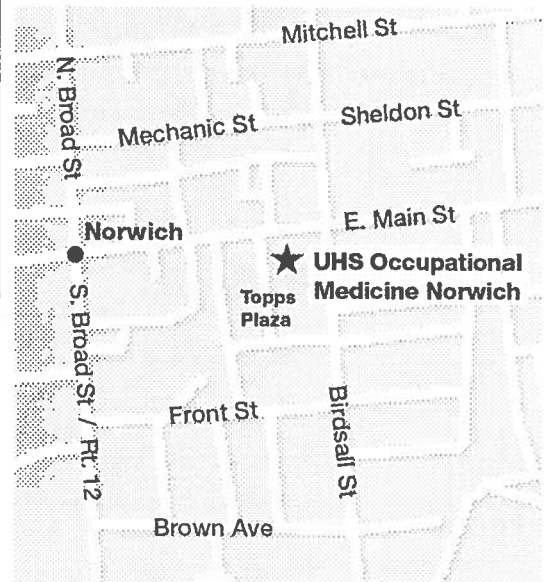
Date:
Employee Name:
Social Security #:
Date of Birth:

Hours: Mon. - M-F 8:00am-12:00pm;
1:00pm-4:30pm
(No appointment necessary)

REQUEST FOR SERVICES
It is understood and agreed that the services requested will be performed as described in the Catalog of Employer Services. The undersigned hereby agrees to indemnify UHS Occupational Medicine/United Health Services Hospitals, Inc. as provided in the letter accompanying or included in said Catalog, and to pay UHS Occupational Medicine/United Health Services Hospitals the rate specified in the current UHS Occupational Medicine fee schedule.

Signature and Title _____
Date/Time

Phone: (607) 337-4777
Fax: (607) 337-4778



PLEASE CHECK ALL SERVICES DESIRED

Workers' Compensation Injury Care

- First Aid Evaluation and Treatment

Post Accident Testing:

- Drug Test Breath Alcohol Test DOT Non-DOT

PHYSICAL EXAMINATIONS

- New Hire (General Physical) Annual
- Fitness for Duty (Call Ahead) Physical Demands Screen (Lift Test)
- Return to work (Call Ahead)

- New Hire Specific Job Placement (based on physical ability to perform job and jobsite evaluation by UHS Hospitals must be completed)

Applicant's proposed job title _____
(Regarding Specific Job Placement Only) (title provided by employer)

Free parking Free Parking is available in the parking lot in front of UHS Occupational Medicine at the Top's Plaza in Norwich.

DRUG AND ALCOHOL TESTING (NON-DOT)

*** Photo identification required ***

- Drug Screen:**
- Panel 5 Narcotic Panel
 - Panel 9 Panel 10
 - Hair Collection Only Panel 10
 - Hair Test Breath Alcohol
 - Urine Collection Only/No Medical Review Officer (MRO)

Reason for Test (please check type):

- Pre-employment Random
- Post Accident Reasonable Cause
- Return to Work Follow-up
- Other (specify) _____

DRUG AND ALCOHOL TESTING (DOT)

*** Photo identification required ***

- Urine Collection Only/No MRO
- Breath Alcohol
- Drug Screen

Reason for Test (please check type):

- Pre-employment Random
- Post Accident Reasonable Cause
- Return to Work Follow-Up
- Other (specify) _____

Department of Transportation (DOT) Exams

- DOT Exam: _____ Preplacement _____ Recertification
- 19 A Exam: _____ Preplacement _____ Recertification

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- | | |
|--|--|
| <input type="checkbox"/> Audiometric Testing (29 CFR 1910.95) | ___ Baseline ___ Annual ___ 30 Day Recheck |
| <input type="checkbox"/> Bloodborne Pathogen Exposure (29 CFR 1910.1030) | ___ Initial ___ Follow-up |
| <input type="checkbox"/> Formaldehyde Exam (29 CFR 1910.1048) | ___ Preplacement/Initial ___ Annual/Periodic |
| <input type="checkbox"/> HAZMAT Exam (29 CFR 1910.120) | ___ Preplacement/Initial ___ Annual/Periodic |
| <input type="checkbox"/> Hazardous Waste Operations (29 CFR 1910.120) | ___ Preplacement/Initial ___ Annual/Periodic |
| <input type="checkbox"/> Lead Medical Surveillance (29 CFR 1910.1025) | ___ Preplacement/Initial ___ Annual/Periodic |
| <input type="checkbox"/> Methylene Chloride Exam (29 CFR 1910.1052) | ___ Preplacement/Initial ___ Annual/Periodic |
| <input type="checkbox"/> Respirator Suitability (29 CFR 1910.134) | ___ Preplacement/Initial ___ Annual/Periodic |
- Other (specify) _____
- Asbestos Exam (29 CFR 1910.1001)
- ___ Preplacement/Initial with "B" Reader Chest X-Ray
- ___ Annual/Periodic (with "B" Reader Chest X-Ray ___ Yes ___ No)

FREQUENCY OF CHEST X-RAY			
Years since first exposure	Age of employee		
	15 to 35	35+ to 45	45+
0 to 10	Every 5 years	Every 5 years	Every 5 years
10+	Every 5 years	Every 2 years	Every 1 year

Immunizations

- Hepatitis A Vaccine
- Hepatitis B Vaccine
- Measles, Mumps, Rubella (MMR) Vaccine
- Tetanus Toxoid Booster
- Tetanus, Diphtheria, Pertussis (Dtap)
- Tetanus Diphtheria (Td)
- Rabies Vaccine
- Varicella Vaccine
- International Travel (specify) _____
- Other (specify) _____

Ancillary Testing Services

- Tuberculin Skin Test (PPD)
- Rubella Titre
- Rubeola Titre
- Hepatitis B Titre (quantitative)
- Mumps Titre
- Varicella Titre
- Lead Level
- Zinc Protoporphyrin
- Heavy Metal Screen
- 2 View Chest X-Ray
- Other (specify) _____

Industrial Rehabilitation Services

- Worksite Assessment

Special Instructions: