

# AUTHORIZATION FORM

Appt. Date/Time (If applicable): \_\_\_\_\_ / \_\_\_\_\_ /20 \_\_\_\_\_ @ \_\_\_\_\_ am  
pm

\_\_\_\_\_ gives permission to have  
*Employer*

\_\_\_\_\_ SS# \_\_\_\_\_  
*Employee Name*

present to Baptist Health Occupational Health for the following screening services:

**Location To Be Seen:**

BH Occupational Health Campus Clinic  
9600 Baptist Health Drive  
Suite 250  
Little Rock, AR 72205  
501-202-7125

BH Occupational Health River Port Clinic  
6800 Lindsey Road  
Little Rock, AR 72206  
501-490-1633

Pre-Employment     Return to Work     Random     Post Accident     For Cause     Annual

**(PHOTO ID REQUIRED FOR ALL DRUG SCREENS AND PHYSICALS)**

<p><b>Drug Screen</b></p> <input type="checkbox"/> 5 Panel DOT <input type="checkbox"/> 5 Panel <input type="checkbox"/> 7 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/> 12 Panel <input type="checkbox"/> Other _____	<p><b>Alcohol Testing</b></p> <input type="checkbox"/> DOT ( <i>breath</i> ) <input type="checkbox"/> Non-DOT ( <i>breath</i> ) <input type="checkbox"/> Blood Alcohol <input type="checkbox"/> Urine Alcohol <input type="checkbox"/> Other _____	<p><b>Physicals</b> (<i>Call for Appointment</i>)</p> <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Other _____	<p><b>X-Ray</b></p> <input type="checkbox"/> Chest 1 View <input type="checkbox"/> Chest 2 View <input type="checkbox"/> Other _____
<p><b>Lab</b></p> <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> U/A <input type="checkbox"/> Hep B Antibody (Titer)	<p><b>Injections</b></p> <input type="checkbox"/> Hep B <input type="checkbox"/> Hep A <input type="checkbox"/> Flu <input type="checkbox"/> Tdap <input type="checkbox"/> Other _____	<p><b>Compliance Screening</b></p> <input type="checkbox"/> Hearing Screen <input type="checkbox"/> PFT (Spirometry) <input type="checkbox"/> Respirator Fit <input type="checkbox"/> OSHA Questionnaire Review <input type="checkbox"/> Physician Certification W/Exam <input type="checkbox"/> Physician Certification W/O Exam <input type="checkbox"/> TB Skin Test	<p><b>Fitness Testing</b></p> <input type="checkbox"/> Lift Test ___ lbs <input type="checkbox"/> Step Test <input type="checkbox"/> Kneel/Stand Test <input type="checkbox"/> Other _____
<p><b>Work Injury/Condition</b>          Worker's Compensation Insurance Carrier: _____          The FIRST REPORT OF INJURY is the responsibility of the employer and must be made prior to treatment.</p>			

\_\_\_\_\_  
*Authorizing Employer Representative Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Authorized Signature*

\_\_\_\_\_  
*Phone*

Applicants/Employees should arrive 15 minutes prior to their appointment. Please be prepared to offer a specimen upon arrival. Call the clinic location above with any questions.

The Employer is responsible for all charges incurred during the evaluation and treatment of an employee sent to this facility until the employee is discharged from care OR the physician receives written notification of a denial of claim.

## Baptist Health Occupational Health Clinic

Doctor's Park, 9600 Baptist Health Drive, Suite 250, Little Rock, AR 72205

501-202-7125



## Baptist Health Occupational Health Clinic

Little Rock Port Authority, 6800 Lindsey Road, Little Rock, AR 72206

501-490-1633

