

REQUEST FOR MEDICAL CARE AND/OR TESTING

Please acknowledge this form as authorization to perform the following services for our employee:

Employee Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Company Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

_____ Injury Treatment
_____ Fit for Duty / Return To Work
_____ Breath Alcohol Testing (B.A.T.)

_____ Drug Testing
_____ Rapid Test
_____ D.O.T. Mandated
_____ SAP - 5
_____ Collection only

For Injuries:

Date of injury/occurrence: _____ Time of injury: _____

Description of injury: _____

Job Title: _____

Length of time at current job: _____ Length of employment: _____

Full / part-time: _____ Shift worked: _____

Hours per shift: _____ Hours per week: _____

Ability of company to accommodate modified/alternative work:

Always Sometimes/Limited Unavailable Other _____

Company contact: _____

Phone: _____ Fax: _____

Employee: *This form shall be given to medical provider at time of visit. After your medical visit, return Illness / Injury Report to your supervisor.*

Occupational Medicine Department Fax Locations: Urbana Fax: (217) 383-3519,
Rantoul Fax: (217) 893-7801, Danville Fax: (217) 431-7786, Bloomington Fax: (309) 664-3296.