

Authorization for Treatment or Examination

Employee Name: _____ SSN: _____ - _____ - _____

Department: _____ Date: _____

Authorized by: _____ (Supervisor's Signature)

Authorized by: _____ (Supervisor's Printed Name)

Phone: _____

PTAO:

P T A O

Special Instructions/Comments: _____

Note: The employee's department will be billed for services rendered, and the department will be responsible for payment, with the exception of services related to a workers' compensation claim. All workers' compensation charges will be billed to the WC carrier or the employee's health insurance, should the worker's compensation claim be denied by the WC carrier.

Check requested services:

Work Related Assessment
 Injury
 Illness

Infectious Disease Exposure
 Blood, Body Fluid
 Disease

Physical Exam
Type: _____

Fitness for Duty/Limited
 Illness
 Injury

Animal Protocol

Fitness for Duty/Comprehensive

Environmental Exposure Assessment
Type: _____

Immunization
Type: _____

Medical Surveillance
Type: _____

Labwork
Type: _____

New Employee Health Assessment

Annual Assessment

Ergonomics Evaluation

PPD Assessment

Other: _____

Hours of Operation: Monday – Friday 8:00 a.m. – 4:30 p.m. (closed Noon – 1 p.m. Fridays)

Appointments required for all visits other than emergencies.

After hours emergencies should report to the UVa Emergency Department