UNIVERSITY of VIRGINIA HEALTH SYSTEM

UVA-WorkMed

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:____

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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.

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Check requested services:

☐ Work Related Assessment
- ☐ Injury
- ☐ Illness

☐ Physical Exam
Type:_____________

☐ Animal Protocol

☐ Environmental Exposure Assessment
Type:_____________

☐ Medical Surveillance
Type:_____________

☐ New Employee Health Assessment

☐ Ergonomics Evaluation

☐ Other:________________

☐ Infectious Disease Exposure
- ☐ Blood, Body Fluid
- ☐ Disease

☐ Fitness for Duty/Limited
- ☐ Illness
- ☐ Injury

☐ Fitness for Duty/Comprehensive

☐ Immunization
Type:________________

☐ Labwork
Type:________________

☐ Annual Assessment

☐ PPD Assessment

☐ Urine Drug Screen

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

UVA-WorkMed
Fontaine Research Park • P.O. Box 800357 • Charlottesville, VA 22908-0357
Phone: 434-243-0075 • Fax: 434-243-0078
www.uvaworkmed.com