

**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

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**