



Occupational Health Services
Authorization for Treatment or Examination

Date: _____

Employee Name: _____

SSN: _____ - _____ - _____

Employer: University

or

Medical Center

Authorized by: _____

Phone: _____

(supervisor)

Dept./Division: _____

Home Code: _____

Special Instructions/Comments: _____

OHS Arrival Time: _____

OHS Discharge Time: _____

Note: The employee's department will be billed for the services provided that are not related to a workers' compensation claim, and will be responsible for payment. All workers' compensation charges will be billed to the WC carrier.

Check requested services:

- Work Related Assessment (Injury, Illness)
Physical Exam (Type)
Environmental Exposure Assessment (Type)
Animal Protocol
New Employee Health Assessment
Medical Surveillance (Type)
Ergonomics Evaluation
Infectious Disease Exposure (blood, body fluid, disease)
Fitness for Duty/Limited (Illness, Injury)
Fitness for Duty/Complete
Immunization (Type)
Labwork (Type)
Annual Assessment
PPD Assessment
Other

Location and Hours of Operation: 337 15th Street, S.W.
Monday - Friday 8:00-4:30pm
(closed 12-1pm on Thursdays)

Appointments required for all visits other than emergencies
After hours emergencies should report to the UVa Emergency Department