



**OCCUPATIONAL
MEDICAL SERVICES**
Your Partner in Employee Health

PLEASE CALL TO MAKE AN APPOINTMENT

**EMPLOYER'S AUTHORIZATION
FOR MEDICAL TREATMENT**

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

(PLEASE- NO UNSUPERVISED CHILDREN UNDER 10 YEARS OF AGE IN CLINIC)

Patient Name:		Company Name:	
SSN:		Location #/Street Address:	
Date of Birth:		Temporary Staffing Agency:	
WORK-RELATED	<input type="checkbox"/> Injury	<input type="checkbox"/> Illness	VACCINATIONS
DATE OF INJURY:		<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis A
POST ACCIDENT TESTING		<input type="checkbox"/> PPD	<input type="checkbox"/> Flu Vaccine
<input type="checkbox"/> Drug Screen	<input type="checkbox"/> DOT Regulated	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Breath Alcohol	<input type="checkbox"/> Non-Regulated	<input type="checkbox"/> Blood Draw - Specify Test	
<input type="checkbox"/> Collection only			
PHYSICAL EXAMS - Check Exam Requested		X-RAYS	
<input type="checkbox"/> Post-Offer Physical Exam		<input type="checkbox"/> Chest x-ray (1 view)	
<input type="checkbox"/> DOT Exam - Non CDL		<input type="checkbox"/> Chest x-ray (2 view)	
<input type="checkbox"/> DOT Exam - New Certification		<input type="checkbox"/> Chest x-ray (1 view) W/B-Reader	
<input type="checkbox"/> DOT Exam - Recertification		<input type="checkbox"/> Chest x-ray (2 view) W/B-Reader	
<input type="checkbox"/> Respiratory Exam		<input type="checkbox"/> Other - Please specify	
<input type="checkbox"/> Hazmat Exam			
<input type="checkbox"/> Asbestos Exam			
<input type="checkbox"/> Performance Evaluation			
SUBSTANCE ABUSE TESTING		OTHER TESTING	
<input type="checkbox"/> Urine Drug Screen - DOT Regulated		<input type="checkbox"/> Pulmonary Function Test	
<input type="checkbox"/> Urine Drug Screen - Non Regulated		<input type="checkbox"/> Audiogram (Hearing Test)	
<input type="checkbox"/> Collection Only		<input type="checkbox"/> Vision	
<input type="checkbox"/> Instant Test		<input type="checkbox"/> Respiratory Fit Testing	
<input type="checkbox"/> Breath Alcohol - DOT Regulated			
<input type="checkbox"/> Breath Alcohol - Non DOT Regulated			
REASONS FOR TEST		BILLING	
<input type="checkbox"/> Post Offer		<input type="checkbox"/> Employee to pay at time of service	
<input type="checkbox"/> Random		<input type="checkbox"/> Bill my company	
<input type="checkbox"/> Post Accident/Injury		<input type="checkbox"/> Bill workers' compensation carrier	
<input type="checkbox"/> Follow-up		Insurance Company Name _____	
<input type="checkbox"/> Reasonable Suspicion		Policy # _____	
		Phone # _____	

I authorize OMS to provide this employee with the medical attention provided above. I further acknowledge my company's responsibility for the payment of services.

Authorized By: (Print)

Authorized Signature:

Phone:

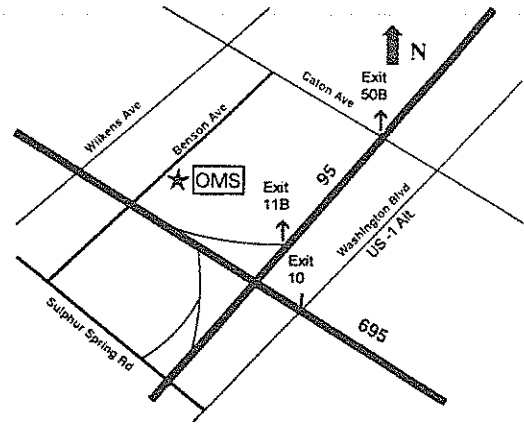
Date:

OMS-ARBUTUS

Beltway Corporate Center
4807 Benson Avenue
Baltimore, MD 21227
Phone: 443-524-2737
Fax: 443-524-2742

Hours of Operation:

24 Hours - Monday 7:00am thru Saturday Noon



OMS-CANTON

3600 O'Donnell Street • Suite 170
Baltimore, MD 21224
Phone: 410-534-1203 • Fax: 410-534-1205

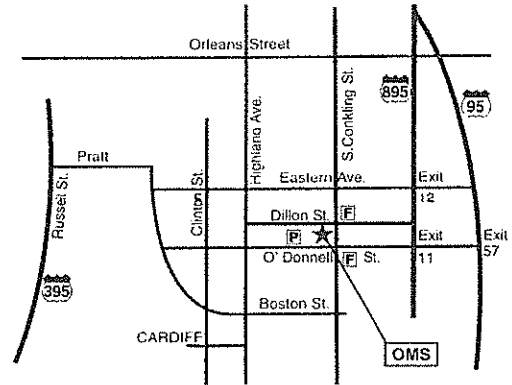
Hours of Operation:

Mon. thru Fri. 7:30am - 5:00pm

Metered Parking in Front

Free Parking Across the Street at BravoHealth, on
Dillon St. and across from Medical Center

MTA #13 stops on Boston Street

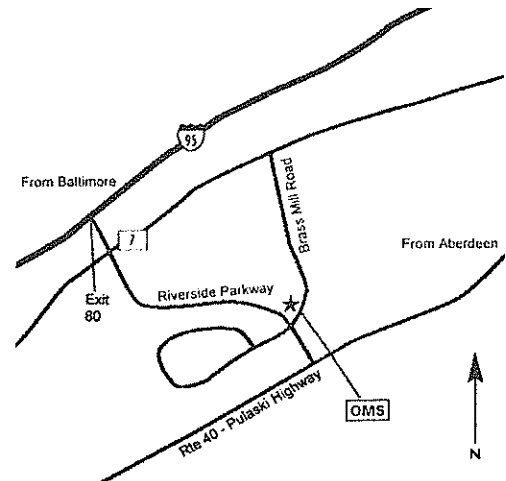


OMS-BEL AIR/ABERDEEN

1200 Brass Mill Road
Suite C
Belcamp, MD 21017
Phone: 410-272-7756
Fax: 410-273-7694

Hours of Operation:

Monday thru Friday 7:30am - 5:00pm



OMS-GREENBELT

7933 Belle Point Drive
Greenbelt, MD 20770
Phone: 301-220-1191
Fax: 301-220-2291

Hours of Operation:

Monday thru Friday 8:00am - 4:30pm

