

AUTHORIZATION FOR MEDICAL SERVICES

COMPANY NAME Howard County Government		EMPLOYEE'S NAME	
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	PRINTED NAME
TITLE		PHONE NO.	

_____ **Work-Related Injury** **Date of Injury:** _____

PHYSICAL EXAMS **Check examination requested.** Please request any other testing below.

- _____ Profile 1 (Sedentary)
- _____ Profile 2 (Field/ Technical)
- _____ Profile 3 (Light /Manual)
- _____ Profile 4 (Heavy/ Manual)
- _____ Profile 5 (Public Safety - Police)
- _____ DOT Exam – New certification **CDL** ___ **Non-CDL Physical Card Only** ___
- _____ DOT Exam Re-certification **CDL** ___ **Non-CDL Physical Card Only** ___
- _____ Other: _____

OTHER TESTING

- _____ Stress Test _____ Chest X-Ray ___ 2 View
- _____ Chest X Ray B Read
- _____ Hepatitis B Titer
- _____ Respirator Fit Testing - Quantitative
- _____ Respirator Fit Testing - Qualitative
- _____ Lab (Specify) _____

IMMUNIZATIONS/VACCINATIONS

- _____ Hepatitis B _____ Hepatitis A _____ Twinrix (HepA&B Combo)
- _____ TDAP _____ Typhoid
- _____ TB Skin Test (PPD) _____ Flu Vaccine
- _____ Other (specify) _____

SUBSTANCE ABUSE TESTING (Must have photo ID) Check type of test(s) and reason for test

TEST REQUIRED:

REASON FOR TEST:

- | | |
|---|--------------------------------|
| _____ Urine Drug Screen w/MRO - DOT** | _____ Pre-placement/Post Offer |
| _____ Urine Drug Screen w/MRO – Non DOT | _____ Reasonable cause |
| _____ Urine Drug Screen - COMAR Police | _____ Follow-up |
| | _____ Random |
| _____ Breath Alcohol Test – DOT | _____ Post Accident |
| _____ Breath Alcohol – Non DOT | _____ Return to Duty |
| | _____ Promotion |

****For Federal Drug Testing, please specify Testing Authority:**

_____ HHS _____ NRC _____ DOT - Please Specify DOT Agency:
_____ FMCSA _____ FAA _____ FRA _____ FTA _____ PHMSA