CEDAR VALLEY
Occupational Health
A branch of CVMS

Hours:
Monday - Friday
8 a.m. - 5 p.m.

CedarValleyMedical.com

Patient Name: _____ Date of Birth: _____

Company: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorized by: _____ Date: _____

Work-Related Injury/Illness	Specific Body Part: _____ - If this incident is deemed not work-related, the authorizing organization will be responsible for charges prior to written notification.
DOT	☐ Drug Screen ☐ Alcohol Screen ☐ Pre-Placement ☐ Post-Accident ☐ Reasonable Suspicion ☐ Random ☐ Follow-up ☐ Witness/Observed ☐ Employee to Pay
Non-DOT	☐ Drug Screen ☐ Alcohol Screen ☐ Pre-Placement ☐ Post-Accident ☐ Reasonable Suspicion ☐ Random ☐ Follow-up ☐ Employee to Pay ☐ 5-panel ☐ 5-panel NO THC ☐ 7-panel ☐ 10-panel
Physical Exam *(check all that apply)*	☐ DOT ☐ Return to Work ☐ Pre-Placement ☐ Respiratory Clearance ☐ Employee to pay ☐ Other: _____
Immunization *(check all that apply)*	☐ Hep B ☐ Flu ☐ TB ☐ Tdap ☐ Employee to pay ☐ Other: _____
Other Services *(check all that apply)*	☐ PFT ☐ Audiometry ☐ Fit Test ☐ Other: _____ _____ _____

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