Occupational Medicine Service Authorization

Complete/sign & return with Ownership Certification for account activation

Bell
901 Lakeshore Drive, Suite108
Ishpeming, MI 49849
906.485.2267/Fax: 906.485.2752
Jennifer.Koski@lifepointhealth.net
Diana.sundberg@lifepointhealth.net

Doctors Park
710 S. Lincoln Road, Suite 800
Escanaba, MI 49829
906.786.0440/Fax: 906.789.8799
occmed@mghs.org

Peninsula Medical Center
1414 West Fair Avenue, Suite 35
Marquette, MI 49855
906.449.1140/Fax: 906.449.1844
occmed@mghs.org

□ New Account □ Account Update/Reactivation

Company Name (or Third Party, as applicable): _____

Address: _____

Name of Company Representative Authorizing Service (please print): _____

Signature of Authorizing Representative: _____ Date: ____/____/____

Primary phone number of Authorizing Representative: _____ Mobile/other: _____

Drug and Alcohol Testing

□ **Collection only**; please send your CCF(s) with donor(s)
- ○ FormFox electronic collections *(available in Marquette only)*

□ **UPHS Occupational Medicine lab panels with our MRO**
- ○ Federal/DOT 5 panel urine drug test
- ○ Non-regulated 5 or 10 panel urine drug test, (circle one)
- ○ 6 panel Police Officer urine drug test
- ○ Rapid 6 panel urine drug *test* *(not available at Bell yet)*
- ○ Rapid 10 panel urine drug test
- ○ 5 panel HAIR drug test

Please phone for more urine drug testing options

□ **Breath Alcohol Testing:** ○ Federal/DOT ○ Non-regulated

Designated Employer Representative (DER)

(For confidential discussion regarding drug/alcohol testing as needed)

Name: _____
Phone #: _____
E-mail address: _____

Alternate DER:

Name: _____
Phone #: _____
E-mail address: _____

Invoice to (Name): _____
Address: _____
_____
Phone/email: _____/_____

For accounts designated as service date payment required:
Credit Card number: _____
Expiration date: _____/_____ Security code: _____

Physical Exams

□ **Post-offer/Pre-placement**, includes vision testing
Job title(s): _____

□ **Employer/TPA specific exam**: *please provide details including all documents that need to be completed/reviewed*

_____

Regulated exams:

□ **Asbestos** □ **HAZMAT** □ **Silica**
□ **Medical Exam for CDL** □ **MCOLES**
□ **Respirator Medical Clearance**
□ *Audiogram* □ OSHA/MIOSHA hearing conservation
□ *Other Lab/Imaging/Ancillary Testing:*

_____

_____

TB testing and Immunizations

□ TB skin test □ Hepatitis B vaccine □ Flu vaccine
□ QuantiFERON-TB Gold □ Tdap vaccine □ Td vaccine
□ MMR vaccine

Preferred method for results: email, fax, or mail (circle one)

Results to: (name/contact info)

Preferred 10-digit password: __ __ __ __ __ __ __ __ __ __

If receiving results via email, they are encrypted/password protected.

Workers Compensation

Insurance Company: _____
Address: _____

Phone/email: _____/_____

Please provide employee claim number by 2nd visit

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