



OCCUPATIONAL HEALTH

AUTHORIZATION FOR EXAMINATION, TREATMENT, OR TESTING

Patient Name: _____

SSN: _____

Employer: _____

DOB: _____

Physical Examination

Preplacement Annual Exit

DOT Recertification

Fit for Duty HazMat

Work Related

Injury

_____ Date of Injury / Illness

Drug & Alcohol Testing (Check all that apply)

DOT Drug Screen Collection Only

Non DOT Screen Breath Alcohol

Instant (Rapid) Other

Reason for Drug Testing

Pre-Placement Random

Reasonable Cause Post Accident

Post Injury Other

Special Testing

Spirometry Audiogram Vision

Other _____

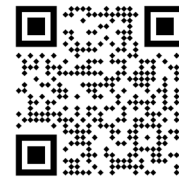
Special Instructions/Comments _____

Date: _____ Time: _____

Company Phone #: _____

Authorizing Individ- _____

Company Contact: _____



*Scan for Address
& Directions*

Address

8630 F Street
Omaha, NE 86127

Hours

8:00am - 5:00pm

Contact

402.898.5600 (office)

402.898.5605 (fax)

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