direct REHABMED BUSINESS HEALTH

C PERRY MARSHALL, M.D.

EMPLOYEE / PATIENT CONSENT FOR EXAMINATION OR TREATMENT

Today's Date ______________________ Arrival Time: ______________________

Name: ________________________________ SS#: ______________________ DOB: __________

Company Requesting: ____________________________ Department you work for: ________________

Your Address: ________________________________ City/St/Zip: ______________________

Home Phone: ____________________________ ☐ cell or ☐ work telephone: ______________________

Present Employer: ________________________________ Work Phone: ______________________

I, ________________________________, hereby authorize **C Perry Marshall, MD, DRM Business Health, PLLC**, their employees, agents or assigns (hereinafter referred to as "Providers") to make a report to my employer, business, institution or other party as listed above concerning the collection and/or results of drug screens, physicals, breath alcohol testing, audiometry, spirometry and any other test requested by my employer or requesting party for consideration of employment, continued employment, or work related injury or reason established by police or party requesting the testing. I hereby authorize the use of these test results for the limited purpose listed herein and I understand that the requesting party has an independent duty to protect the confidentiality of the information released to the employers by Providers. Therefore, I hereby release Providers from any liability for damages to me, my family, agents or assign resulting directly or indirectly from Providers release of this information to the requesting party. I further understand that I have the right to withdraw my consent to the release of information; however, withdrawal of my consent does not affect any information disclosed prior to the written notice of my request for withdrawal. The undersigned, by signing this document represents that he/she has read and understands the above information and hereby consents to voluntarily submitting to the requested tests and the release of any resultant from information available learned from the results of the test to the requesting party listed above.

Signature: ____ Date: ______________________

Witness: ____

OFFICE USE ONLY

INJURY/ILLNESS **Date of Injury**________________

☐ **Treat for Work Related Injury / Illness**

DRUG & ALCOHOL TESTING
- ☐ DOT or ☐ Non-DOT
- ☐ E-Screen
- ☐ Specimen Collection Only
- ☐ Hair Drug Test
- ☐ Breath Alcohol Testing (BAT)
- ☐ Urine Alcohol Testing

PHYSICAL
- ☐ DOT or ☐ Non-DOT
- ☐ Executive (Company)
- ☐ FAA
- ☐ Other ______________________

Staff Comments: ______________________

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Air Bill # (if applicable) ______________________

POST OFFER OF EMPLYMENT & FIT FOR DUTY
- ☐ POET
- ☐ Fit for Duty Evaluation
- ☐ Carpel Tunnel Screen

X-RAYS
- ☐ 5 View Back
- ☐ 3 View Back
- ☐ Chest
- ☐ Other ______________________

OTHER SERVICES
- ☐ Spirometry – (Pulmonary Function Test)
- ☐ Audiometry Testing ☐ OSHA Compliant Test (Booth)
- ☐ Respirator Fit Test If with BH mask circle
- ☐ Resp. Questionnaire
- ☐ EKG ☐ Grip Test
- ☐ Immunizations ______________________
- ☐ Other ______________________

Notification of Results to:	Date/Time:	Mailed/Faxed/E-mailed:	DOT Filed:

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