



Seton Occupational Health Center

1345 Philomena St., STE 102

Austin, TX 78723

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EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(Must Present Photo Identification at Time of Service)

Patient Name		Social Security Number	
Company Name		Date of Birth	
Company Address		Date of Injury	
Please Check as Appropriate Work Related: Injury <input type="checkbox"/> Illness <input type="checkbox"/> Evaluation & Treatment <input type="checkbox"/> Drug Screen <input type="checkbox"/> Urine Collection ONLY <input type="checkbox"/> Urine Test: DOT Regulated <input type="checkbox"/> Non-Regulated <input type="checkbox"/> OTHER TEST: _____		Comments	
PHYSICAL EXAM	PRE-PLACEMENT <input type="checkbox"/>	Asbestos <input type="checkbox"/>	D.O.T. Pre-placement <input type="checkbox"/>
	ANNUAL <input type="checkbox"/>	Haz Mat <input type="checkbox"/>	D.O.T. Recertification <input type="checkbox"/>
	EXIT <input type="checkbox"/>	Return to Work <input type="checkbox"/> (Attach Job Description)	
BILLING	<input type="checkbox"/> Bill Company for Services <input type="checkbox"/> Bill Worker's Company Carrier Carrier Name: _____ Policy Number: _____ Phone Number: _____ Address: _____ : _____		
	Authorized By: _____	Title: _____	
Phone: _____	Date: _____		
Contact Name: _____	Contact Phone: _____		