

### Employer Authorization for Care

Date / Time: \_\_\_\_\_ Company: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor signature: \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
to receive medical attention as indicated below.

Position: \_\_\_\_\_

**Exams**

- Preplacement Basic exam only
- Combined Preplacement & DOT exam
- DOT Certification
- DOT Recertification
- Surveillance (HazMat)
- Respirator Clearance
- Other

**Alcohol & Urine Drug Testing (Photo ID Required)**

- |                                                                                                                                                                                                                                                                              |                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> DOT or Federally regulated <ul style="list-style-type: none"><li><input type="checkbox"/> Urine Drug Collection</li><li><input type="checkbox"/> Breath Alcohol</li><li><input type="checkbox"/> Both</li></ul>                                     | <b>Reason for Test</b>                        |
| <input type="checkbox"/> Non-DOT or Non Fed. <ul style="list-style-type: none"><li><input type="checkbox"/> Urine Drug Collection</li><li><input type="checkbox"/> Blood Alcohol</li><li><input type="checkbox"/> Breath Alcohol (signed indemnification required)</li></ul> | <input type="checkbox"/> New Hire             |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Random               |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Reasonable Suspicion |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Post Accident        |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Return to Duty       |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Follow up testing    |
|                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Other _____          |

\*Federal Regulated DOT Drug Screens Unavailable at Blaine Medical Center\*

**Work-Related Injury / Illness**

Type of injury / illness: \_\_\_\_\_ Date of injury: \_\_\_\_\_

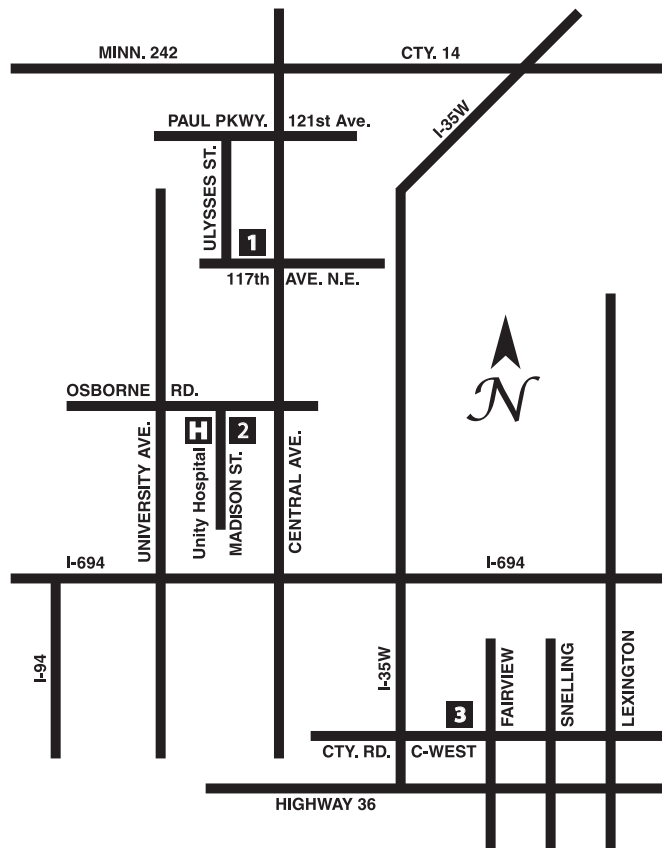
Workers Compensation Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>ROSEVILLE MEDICAL CENTER</b> Twin Lakes Health Building 1835 County Rd. C West Roseville, MN 55113  Corner of Cty. Rd. C and Fairview 763-785-4300  M,W, & Th... 7:30 am – 8:00 pm Tues & Fri... 7:30 am – 5:00 pm	<b>FRIDLEY MEDICAL CENTER</b> 7675 Madison St. NE Fridley, MN 55432  Across from Unity Hospital 763-785-4500  M-F... 8:00 am – 8:00 pm Sat... 8:00 am – 12:00 Noon	<b>BLAINE MEDICAL CENTER</b> 11855 Ulysses St. NE Blaine, MN 55434  117 <sup>th</sup> Ave. NE – off Hwy 65 763-785-4200  M-Th... 8:00 am – 8:00 pm Fri... 8:00 am – 5:00 pm
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**\*SERVICES MAY VARY BY SITE\***

**\*DRUG SCREEN COLLECTION AVAILABLE UNTIL 5:00 PM Monday – Friday\***

MULTICARE  
ASSOCIATES  
MEDICAL CENTERS



<b>1</b>	<b>Blaine Medical Center</b>	763.785.4200
<b>2</b>	<b>Fridley Medical Center</b>	763.785.4500
<b>3</b>	<b>Roseville Medical Center</b>	763.785.4300

Welcome to Multicare Associates Clinics!

Today you will undergo an occupational health physical exam.

This may be a preplacement exam, a DOT exam, or an exam for another purpose.

To orient you to the process we have prepared this information.

To begin you will be asked to complete some forms, which will vary depending on the type of exam.

You may also undergo some laboratory tests, urine tests, breathing or hearing evaluations.

In the exam room your provider will review your health history and/or tests with you.

For the physical exam, you may be asked to disrobe to your undergarments. A gown will be provided, and/or an attendant as indicated. The specifics of the exam may change depending on the purpose, but the standard components include the following:

- o Eyes, ears, nose, throat
- o Neck and thyroid
- o Heart & lungs
- o Abdomen including hernia check
- o Spine, joints and muscles
- o Neurologic system

Preventive health tests, such as cholesterol, pelvic, breast and rectal evaluations are not included, so these should still be scheduled with your regular physician.

We recommend the day of your physical you:

- o Limit your caffeine use
- o Take your regular medications on time
- o Come rested for your exam
- o Complete any paperwork given to you before arriving at the clinic.

If you have any questions, please ask your nurse or provider.

We hope this information is helpful.