

## CLIENT AUTHORIZATION FORM

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

*Authorization will be honored through 5PM on expiration date*

Company: \_\_\_\_\_

Plant # (if applicable): \_\_\_\_\_

Y   N

Employee/Applicant works through Temp. Agency? Y   N   Temp. Agency: \_\_\_\_\_

Employee/Applicant: \_\_\_\_\_

**Reason For Visit:**

- \*Workers Comp. Injury  
(DOI \_\_\_\_\_)
- Pre-Placement Services
- DOT Recertification
- Random Testing
- Post-Accident Testing
- Reasonable Cause Testing
- Respirator Compliance
- Other: \_\_\_\_\_

**Services Needed:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Injury/Illness Treatment</li> <li><input type="checkbox"/> DOT Physical</li> <li><input type="checkbox"/> DOT Drug Test</li> <li><input type="checkbox"/> DOT BAT</li> <li><input type="checkbox"/> Drug Test</li> <li><input type="checkbox"/> Alcohol Test</li> <li><input type="checkbox"/> Physical</li> <li><input type="checkbox"/> Flu Shot</li> <li><input type="checkbox"/> TB Test</li> <li><input type="checkbox"/> Hep B Shot ( 1 2 3 )</li> <li><input type="checkbox"/> Background Check</li> <li><br/></li> <li><input type="checkbox"/> Other: _____</li> </ul> | <ul style="list-style-type: none"> <li><u>Hearing</u></li> <li><input type="checkbox"/> Baseline Test</li> <li><input type="checkbox"/> Annual Test</li> <li><input type="checkbox"/> STS w/Exam</li> <li><br/></li> <li><u>Respiratory</u></li> <li><input type="checkbox"/> PFT</li> <li><input type="checkbox"/> Resp. Fit Test</li> <li><input type="checkbox"/> Resp. Medical Questionnaire</li> </ul> |
|---|---|

Special Instructions: \_\_\_\_\_

Community Occupational Medicine is authorized to provide above services as established in company profile.

\*The Company is authorizing the first visit for determination or treatment of injury or illness & will be responsible for filing with workers compensation insurance or making direct payment if insurance denies.

Company Authorized Signature \_\_\_\_\_

**PICTURE ID REQUIRED  
ADDRESSES/PHONES ON REVERSE**

7 locations in Elkhart, St Joseph, and LaPorte Counties!

22818 Old US 20, **Elkhart**, IN 46516  
(hours: Mon-Fri, 7am-5pm)

Ph (574)389-1231 Fax (574)389-1232  
Email: [elkhart@comocmed.com](mailto:elkhart@comocmed.com)

2312 Eisenhower Dr N, **Goshen**, IN 46526  
(hours: Mon-Fri, 7am-5pm)

Ph (574)534-1231 Fax (574)534-8186  
Email: [goshen@comocmed.com](mailto:goshen@comocmed.com)

1104 W Bristol St, **Elkhart (NW)**, IN 46514  
(hours: Mon-Fri, 7am-5pm)

Ph (574)333-2986 Fax (574)343-2077  
Email: [elkhartnw@comocmed.com](mailto:elkhartnw@comocmed.com)

801 Wayne St, **Middlebury**, IN 46540  
(hours: Mon-Fri, 7am-5pm)

Ph (574)358-0042 Fax (574)358-0157  
Email: [middlebury@comocmed.com](mailto:middlebury@comocmed.com)

2301 N Bendix Dr, Ste 500, **South Bend**, IN 46628  
(hours: Mon-Fri, 7am-5pm)

Ph (574)647-1675 Fax (574)232-5595  
Email: [southbend@comocmed.com](mailto:southbend@comocmed.com)

900 I Street, **LaPorte**, IN 46350  
(hours: Mon-Fri, 8am-5pm)

Ph (219)324-1960 Fax (219)324-1961  
Email: [laporte@comocmed.com](mailto:laporte@comocmed.com)

4630 Vistula Road, **Mishawaka**, IN 46544  
(hours: Mon-Fri, 7am-5pm)

Ph (574) 318-4291 Fax (574) 318-4759  
Email: [mishawaka@comocmed.com](mailto:mishawaka@comocmed.com)