

Monday - Friday from 8 a.m. - 5 p.m. CST
Please use La Porte Hospital Emergency Department for after hours injury care.

Dunes Plaza Complex
220 Dunes Plaza
Michigan City, IN 46360
Phone: (219) 874-3750
Fax: (219) 874-4476

La Porte Horizon Center
311 Boyd Blvd.
La Porte, IN 46350
Phone: (219) 326-2664
Fax: (219) 326-2653

AUTHORIZATION FORM

Company: _____

Date: _____ Visit authorized by (print): _____

Authorized Signature: _____ Title: _____

Phone: _____ Fax: _____

By my signature above, I authorize Workforce Health to see the following employee/applicant. If this is a work-related injury visit, I am authorizing Workforce Health to diagnose and treat this same individual with such medical and surgical services as may be necessary to provide proper care subject to the provision of Indiana law.

Name: _____ Job Title: _____

REASON FOR VISIT

- | | | |
|--|---|---|
| <input type="checkbox"/> Pre-employment/post-offer | <input type="checkbox"/> Random | <input type="checkbox"/> Follow-up/surveillance |
| <input type="checkbox"/> Post-accident/injury | <input type="checkbox"/> Reasonable cause | <input type="checkbox"/> Annual/periodic |

SERVICE REQUESTD

(Picture ID required for all drug tests)

- | | | |
|--|---|--|
| <input type="checkbox"/> W/C initial injury | <input type="checkbox"/> Physical | <input type="checkbox"/> DOT physical (picture ID) |
| <input type="checkbox"/> DOT drug test (picture ID) | <input type="checkbox"/> Non-DOT drug test (picture ID) | <input type="checkbox"/> Breath alcohol (picture ID) |
| <input type="checkbox"/> DS collection only (picture ID) | <input type="checkbox"/> Respiratory clearance | <input type="checkbox"/> PFT/spirometry |
| <input type="checkbox"/> PPD (TB testing) | <input type="checkbox"/> Audiogram (test only) | <input type="checkbox"/> _____ |

Follow protocol on file

Follow instructions below

*If your company does not have a protocol on file, please indicate if drug and alcohol testing is required.

Special Instructions: _____



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