❒ **PEARL CITY**
1245 Kuala Street, St 103
Pearl City, HI 96782
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❒ **KAPOLEI**
890 Kamokila Blvd., Suite 106
Kapolei, HI 96707
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❒ **KAILUA**
660 Kailua Road
Kailua, HI 96734
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F: 808.263.2274

❒ **WAIKIKI**
1860 Ala Moana Blvd., #101
Honolulu, HI 96815
P: 808.921.2273
F: 808.921.2274

# EMPLOYER REQUEST FOR EXAMINATION/TREATMENT

*Please have your employee(s) provide this form at the time of visit. You are also welcome to fax this prior to your employee(s) visit.*
*Form must include a designated employee representative and phone number. No appointment is necessary.*
***Requests are kept for a period of one month from the 'Date of Request indicated.***

**Date of Request:**_____

**Employee Name:**_____ **Date of Birth:**_____

Company Name:_____

Company Phone:_____ Company Fax:_____

Company Address:_____
*Street Address* *City/State/Zip Code*

Designated Employee Rep (DER):_____ DER Phone:_____

## REASON FOR REQUEST OF EXAM/TREATMENT

❒ Pre-employment ❑ Post-Accident ❑ Return-to-Duty ❑ Random ❑ Reasonable Cause

❒ Workers Compensation/Work Related Injury ❑ Other:_____

****Please complete section 'For Work Related Injury Only below*

## ***FOR WORK RELATED INJURY *ONLY****

**Work Restrictions Availability:** ❑ Modified ❑ Light ❑ No Duty Available

❒ **Additional Procedure(s):** ❑ Yes ❑ No (*If yes, please check all that apply in the 'Requested Service(s)below)*

**WC INSURANCE:**_____ **CLAIM NUMBER** *if applicable*:_____

**ADJUSTER NAME:**_____

**PHONE NUMBER:**_____ **FAX NUMBER:**_____

## HOW WOULD YOU LIKE TO RECEIVE RESULTS &/OR MEDICAL TRANSCRIPTIONS

❒ I have an account, please use my account preference

❒ I'd like to use a different route this time: ❑ Fax ❑ Mail ❑ Email Address:_____

****For emails, the temporary password* ***UC1245*** *has been used.*

## REQUESTED SERVICE(S): *Select all that apply*

**DRUG &/OR ALCOHOL SCREENING:**

***Specify DOT Agency (please select one):**

❍FMCSA ❍FAA ❍FRA ❍FTA ❍PHMSA ❍USCG

❒ Non DOT Panel 5 ❑ DOT Panel 5 ❑ Non-DOT Panel 10

❒ Instant Panel 5 ❑ DOT Alcohol Testing **Pearl City Only*

❒ Instant Panel 5 w/ Reflex **Positive results requesting for send out*

**RESPIRATOR:**

❒ Respirator Clearance – (**will proceed to Respirator Physical Exam if failed for Respirator Questionnaire)*

❒ Respirator Physical Exam

❒ Qualitative Respirator FIT Test – (**have employee bring Respirator masks*)

❒ Pulmonary Function Test (PFT)

**IMMUNIZATIONS:**

❒ Tetanus ❑ Flu ❑TB/PPD

❒ Hepatitis B Series – (Series of 3 shots)

❒ Hepatitis A Series – (Series of 2 shots)

**PHYSICAL EXAMINATION** (Vision and Whisper Test included):

❒ Pre-Employment ❑ Return to Work/Fit for Duty/Basic

❒ DOT/CDL Physical ❑ Tiers of Care (DOT/CDL Exclusivity Rates)

**OTHER SERVICES:**

❒ Laboratory *Collection Only (DLS will bill you with additional costs)*

❒ Hep B ❒Hep A ❒CBC ❒ Zinc Protoporhin ❒ Lead ❒Heavy Metal

**X-RAY:**_____

**Body Part:** ❑ Chest ❑ Back: Upper Mid Lower ❑ Finger:_____ ❑ Toe:_____

**Side:** ❑ Left ❑ Right **Views:** ❑ 1 view ❑ 2 views

**Reason:**_____ **Example: Rule out* pneumonia, *asthma, fracture*

EMPLOYER AUTHORIZATION

Authorized by:_____ _____
*Signature* *Print Name*

*By signing I am authorizing services and hereby making a guarantee of payment for services requested on this form.*

Reset Form Print

***Revise date:*** *08/05/2019*