UNIVERSITY HEALTH CENTER
UGA OCCUPATIONAL HEALTH
APPROVAL FOR
PHYSICAL EXAMS, EYE EXAMS, LAB WORK, IMMUNIZATIONS AND X-RAYS

Date: ______________________________

Employee Name: ____ UGA ID: ____________________________ M F

Address: ____ City: ________________________ State: _____ Zip: ______________

Date of Birth: __________________________ Emergency Contact: ____________________ Phone: ________________ Relationship: ______________

Student: ☐Yes ☐ No Faculty/Staff: ☐ Yes ☐ No UGA Employment: ☐ Full-Time ☐ Part-Time

New to Occupational Health Program? ☐ Yes ☐ No E-mail address: ____

Dept.: ____ Bldg.: ____

Work #: ____ Home #: ____

Dept. Acct. Name to be Charged: ____

Dept. Acct. # to be Charged: ____

Dept. Contact Person: ________________________________ Dept. Contact Phone #: ________________________________

Dept. Contact E-Mail: ________________________________ Nature of work ____

Days/Times Available for Appointment: ____

Release of Information: I authorize the University Health Center ("UHC") at The University of Georgia, Athens, GA, to use and disclose this health information to the following individual or organization for the purpose of:

Occupational health and safety Academic program requirements Request of individual Other

Name/Organization:____
Address: ____ ______________
City: ____________________________ State: ___________ Zip code: _____________
Contact person: ____________________________________

UHC may provide health care for the purpose of disclosing to a third party protected health information specifically created for that third party, upon my agreement to use and disclose this information. By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to the University Health Center to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to the University Health Center to the attention of the Manager, Registration and Health Information. The revocation shall be effective except to the extent that UHC has already used or disclosed information in reliance on the Authorization. For more detailed information on how to revoke this authorization, please refer to Notice of Health Information Privacy Practices at www.uhs.uga.edu. I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. Unless otherwise revoked, this authorization will expire on the following date, event or condition:__________________________________ .

Signature: ____ Date: ___________________________

Please check off the appropriate services being requested for the above employee:

MC Green (by Appointment Only) Contact: Joy Brudon 706-542-8650 (ph) 706-583-0352 (fax) jbrudon@uhs.uga.edu	**Allergy / Travel (by Appointment Only)** Contact: Shirley Billups 706-542-5575(ph) 706-583-8255 (fax) sbillups@uhs.uga.edu	**Vision (by Appointment Only)** Contact: Amy Stowers 706-542-5641(ph) 706-227-4763 (fax) astowers@uhs.uga.edu	**Physical Therapy (by Appointment Only)** Contact: Kacina Hewell 706-542-8634 (ph) 706-542-0214 (fax) khewell@uhs.uga.edu
☐ Complete physical w/ chest xray ☐ Complete physical w/o chest xray ☐ Tuberculin Skin Test or ☐ TB Blood Test ☐ Pulmonary Function Test ☐ Post Exposure to Infectious Disease, i.e. rabies, T.cruzi, etc. LABS ☐ Urinalysis (full) ☐ CBC ☐ Rabies titer ☐ Lyme titer ☐ RBC Cholinesterase ☐ Reticulocyte count ☐ Executive profile ☐ EKG ☐ Quantiferon Gold TB ☐ Other	Vaccinations ☐ Rabies vaccination series ☐ Hepatitis A series ☐ Hepatitis B series ☐ Tetanus ☐ Smallpox ☐ Botulism ☐ Inactivated Influenza Vaccine ☐ Live Attenuated Intranasal Vaccine (special order) ☐ International Travel Consultation ☐ Other	☐ Safety Eyewear ☐ Comprehensive eye exam ☐ Contact lens fitting ☐ Vision screening ☐ Color screening ☐ Depth perception screening ☐ Peripheral vision screening ☐ Other	☐ Workstation Evaluation ☐ Functional Movement Screening ☐ Therapeutic Massage ☐ Focused Massage ☐ Other

____
Department Head Signature (required in order to process)

Comments: ____

The approval form is valid up to 12 months from the date submitted. (Please contact the appropriate person above, or Shirley Billups at the University Health Center at 706-542-5575 if you have any questions regarding the completion of this form.)

Eohs-2 frm.approvalugaocchlth DMS – Admin Specialist
Effective: 08/93
Reviewed: 06/94; 07/95; 06/96; 06/01; 10/02; 05/04; 09/05; 07/08; 07/09; 09/09; 09/11; 07/12
Revised: 11/97; 11/98; 02/99; 05/99; 08/00; 06/03; 09/06; 11/06; 07/07; 09/07; 11/09; 05/10; 01/11; 02/11; 01/13; 2/14