ROCC
REGIONAL OCCUPATIONAL CARE CENTER
A UNITY HEALTHCARE PARTNER

☐ ROCC – Regional Occupational Care Center
1321 Unity Place, Suite A
Lafayette, IN. 47905
P 765.446.2450
F 765.446.1083
Monday-Friday 8:00 - 6:00

☐UICC - Unity Immediate Care Center
1321 Unity Place, Suite B
Lafayette, IN. 47905
P 765.446.1362
F 765.446.1007
Monday – Sunday 8:00 - 8:00

AUTHORIZATION FOR TREATMENT

EMPLOYEE NAME: _____ **DOB:** _____

COMPANY: _____ **PHONE: (____)_____-_____**

☐ WORK RELATED INJURY

Date of injury: _____ **Part of body injured:** _____

Post-accident Drug Screen: ☐ YES ☐NO ☐DOT ☐Non-DOT ☐Breath Alcohol ☐After Hours DS $250

☐ BODY FLUID EXPOSURE

Date of exposure: _____ **Part of body involved**: _____

Details: _____

☐PHYSICAL EXAM

☐ DOT ☐ Basic ☐Pre-Employment ☐ Respirator Physical

☐ Respirator Fit w/ OSHA Questionnaire ☐ Other _____

☐INJECTIONS

☐ Tetanus / Tdap ☐ Hepatitis ☐ MMR ☐Varicella ☐ TB Screening

☐ Flu Shot ☐ Other _____ ○Skin Test ○ Quantiferon ○ Chest X-Ray

☐ LABS

☐ Varicella Titer ☐ Hepatitis Titer ☐ MMR Titer ☐ Other _____

☐ DRUG SCREENING ☐ Hair Collection ☐ Nicotine ☐ Breath Alcohol

☐ Urine DOT ☐Urine 5 Panel ☐ Urine 11 Panel ☐ Other _____

REASON: ☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Return to Work

☐ Reasonable Suspicion ☐ After Hours DS $250

I AUTHORIZE THE ABOVE-NAMED EMPLOYEE TO RECEIVE THE SERVICES MARKED AT ROCC AND/OR UICC.

Contact Person: _____ **Phone: (_____)_____-_____**

Signature: _____ **Date:** _____

Authorization:☐ Call In (Name of person filling out: _____) ☐ Hand Delivered