REFERRAL AND AUTHORIZATION FOR TREATMENT

THIS FORM IS TO BE COMPLETED BY COMPANY SUPERVISOR OF ILL OR INJURED PARTY.

MED CENTER

OCCUPATIONAL MEDICINE
WORK RELATED INJURES & ILLNESSES
OPEN 7 DAYS / NO APPOINTMENTS NECESSARY
MON - FRI 8AM - 8 PM
SAT - SUN 9AM - 5 PM

EMPLOYEE ______ SOC. SEC. NO. ______ EMPLOYEE LEFT WORK AT ______

COMPANY Southeast Ventura County YMCA DEPT. ______ TIME IN AT MED CENTER ______

SUPERVISOR Jennifer Guarino PHONE 805.497.3081 TIME OUT AT MED CENTER ______

DATE OF INJURY / ILLNESS ______ TIME ______ PLACE ______

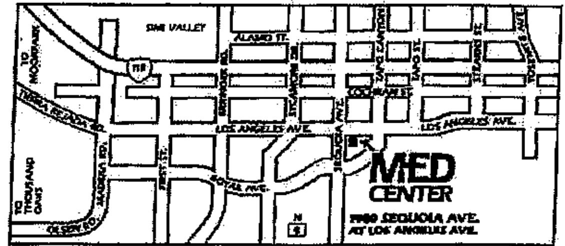
PLEASE CHECK:

- ☑ PRE-PLACEMENT EXAM ☐ SPECIAL EXAM ☐ ILLNESS (WORK RELATED) ☐ BLOOD TEST (SPECIFY AT RIGHT)
- ☐ RETURN TO WORK EXAM ☐ X-RAY (BACK-CHEST) ☐ DRUG SCREEN: ☐ HEARING TEST
- ☐ ANNUAL EXAM ☐ INJURY (WORK RELATED) ☐ DOT ☐ NON-DOT ☐ PULMONARY FUNCTION TEST
- ☐ JOB DESCRIPTION PROVIDED ☐ YES ☐ NO ☐ BREATH ALCOHOL TEST

SUPERVISOR REMARKS: Physical and TB Test

PLEASE CHECK BOXES RELATING TO EMPLOYEE'S WORK ENVIRONMENT:

1. LIFTS ☐ 25 LBS. ☐ 50 LBS. ☐ 100 LBS.
2. ENVIRONMENT: ☐ WET ☐ DRY
3. AIR QUALITY: ☐ DUST ☐ GASES/VAPORS ☐ FUMES
4. COMPANY HAS MODIFIED DUTY: ☐ YES ☐ NO
5. MSDS PROVIDED: ☐ YES ☐ NO
6. PERSONAL PROTECTIVE EQUIPMENT WORN: ☐ YES ☐ NO Type: ______



1980 Sequoia Ave. at Los Angeles Ave. • Simi Valley, CA 93063
(805) 583-5555

OTHER WORK ENVIRONMENT FACTORS ______

SUPERVISOR SIGNATURE Approved by DATE ______

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME
SIMI VALLEY FAMILY YMCA

FACILITY ADDRESS
3200 Cochran Street, Simi Valley, CA 93065

PERSON'S NAME			AGE
POSITION TITLE	TYPE OF FACILITY	WORK DAYS PER WEEK	WORK HOURS PER DAY

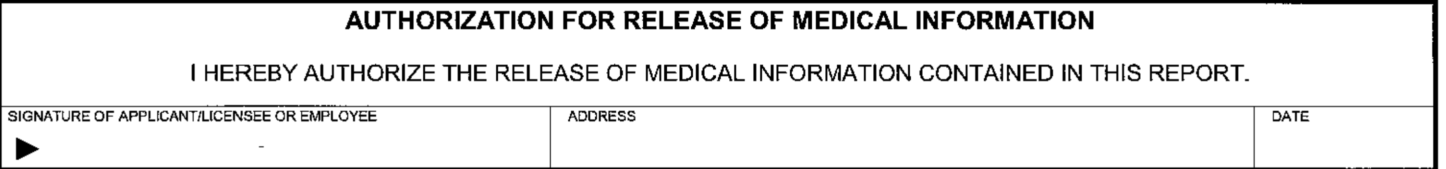
DUTY STATEMENT

Supervise Children

TYPES OF PERSONS SERVED *(Check appropriate items)*

( ) Infants	( ) Adults	( ) Developmentally Disabled	( ) Physically Handicapped
(x) Children	( ) Elderly	( ) Mentally Disordered	( ) Drug/Alcohol Addiction

■ Other *(specify)*



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

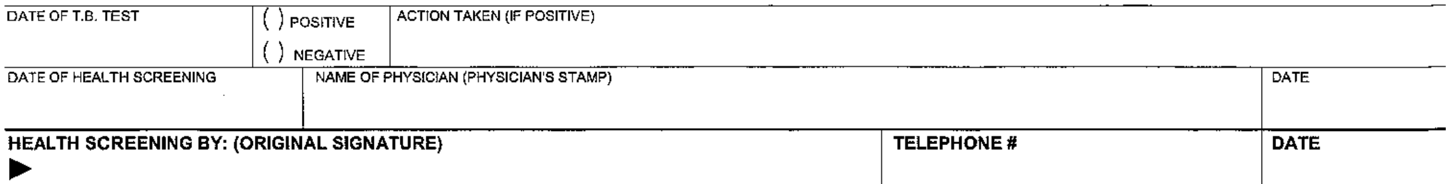
SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
▶		

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL



DATE OF T.B. TEST	( ) POSITIVE ( ) NEGATIVE	ACTION TAKEN (IF POSITIVE)	
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)		DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE)	**TELEPHONE #**	**DATE**
▶		