Care Alliance Health Center

Volunteer & Student Intern Application

Position of Interest: _____ Date: _____

Background Information

This information must be provided in order to be considered for a volunteer or internship position

Contact Information

Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Please check here if you wish to receive email updates from Care Alliance: ☐

Current Employment Information (check all that apply)

☐ Student ☐ Retired ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed

If employed, *please provide the following information:*

Employer: _____ Position: _____

Supervisor Name: _____ Employer Phone: _____

Educational Background

High School Name: _____

Year Completed/Expected Graduation Date: _____

Undergraduate School: _____

Degree Earned/Field of Study: _____

Year Completed/ Expected Graduation Date: _____

Graduate School: _____

Degree Earned/Field of Study: _____

Year Completed/ Expected Graduation Date: _____

Relevant Licenses & Certifications (Attach photocopies of, and list below)

_____

_____

_____

Criminal Background

Have you ever been convicted of a felony (including entering a plea of guilty or nolo contendere)?

☐ Yes ☐ No ***If yes,*** *please provide the date and location of the offense as well as the charge.*

Do not include convictions that were sealed or expunged pursuant to a court order.

Answering "yes" does not automatically disqualify you from volunteer placement at Care Alliance. The circumstances of the offense will be considered in relation to the volunteer position for which you are applying.

Experience & References

In addition to filling in the information below, please submit a copy of your current resume.

Volunteer Experience

Have you volunteered at Care Alliance before? ☐ Yes ☐ No ***If yes,*** *when?*

Have you volunteered at other agencies before? ☐ Yes ☐ No

Describe all volunteer/employment experience relevant to your desire placement at Care Alliance.

Organization	Position	Dates	Capacity	Relevant Experience
			☐ Volunteer ☐ Employee	
			☐ Volunteer ☐ Employee	
			☐ Volunteer ☐ Employee	

Why are you interested in volunteering at Care Alliance?

Are you seeking placement as a requirement of an educational or accreditation program?

☐ Yes ☐ No ***If yes,*** *please provide additional details about the program and requirements below.*

How did you hear about volunteering at Care Alliance?

Character References

Please list three professional references or character references.

Name	Relationship	Phone Number

Areas of Interest

Please check all areas of expertise that you are interested in sharing through this placement.

Medical & Dental Professional

- ☐ Certified Dental Assistant
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Medical Assistant
- ☐ Nurse Practitioner
- ☐ Nutritionist/Dietician
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Patient Educator
- ☐ Podiatrist
- ☐ Physician
- ☐ Psychiatrist/ Psychologist
- ☐ Medical Student
- ☐ RN/LPN

Enabling & Supportive Services

- ☐ Licensed Social Worker
- ☐ Substance Abuse Counseling & Treatment
- ☐ Medical Case Manager
- ☐ Registration/ Intake/Greeter
- ☐ Call Center/Customer Service Specialist
- ☐ Electronic Medical Records
- ☐ Medical Records-Filing
- ☐ Medicare/Medicaid Enrollment
- ☐ Disability Eligibility Specialist
- ☐ Benefits Enrollment
- ☐ Prescription Drug Assistance
- ☐ Prior Authorization Specialist
- ☐ Community Health Worker
- ☐ Health Literacy and Education

Administrative

- ☐ Accounting
- ☐ Billing and Coding
- ☐ Clerical/Data Entry
- ☐ Event planning/Event staff
- ☐ Grant writing & management
- ☐ Information Technology
- ☐ Digital Communications
- ☐ Social Media
- ☐ Video production & editing
- ☐ Graphic Design
- ☐ Web Design
- ☐ Marketing
- ☐ Surveying & Research
- ☐ Media & Public Relations

Please describe any other interests/areas of expertise:

Availability

Please note hours of operation are Monday through Friday, 8 a.m. to 5 p.m. for all clinical/onsite placements. Limited remote/virtual projects available.

Weekly Availability (check all that apply)

☐ Monday		☐ Tuesday		☐ Wednesday		☐ Thursday		☐ Friday	
From	To	From	To	From	To	From	To	From	To

Available Start Date: _____ Length of Commitment: _____

Other Comments about Availability: _____

Care Alliance Health Center

Volunteer Program
Participant Profile and Acknowledgment
Last Updated June 2016

Please print clearly. This form must be updated annually.

Participant Profile

Participant Name: _____

Start Date: _____ Department: _____

Schedule, Frequency or total number of hours: *(Ex.: Mondays 8 a.m. – 2 p.m. through March, or 180 hour externship, etc.)*

_____

Contact information:
Street Address: _____

City, State & ZIP: _____

Phone: _____ Cell: _____

E-mail Address: _____

☐ Check here if you **do not** want to receive monthly e-newsletters from Care Alliance. *I understand if I do not check this box, my email address will be added to Care Alliance's e-newsletter subscription, but that I can unsubscribe at any time without consequence.*

Emergency Contact Information

In case of emergency, please contact:

Name: _____ Relationship: _____

Phone number(s) where they can be reached during your work hours:

Phone: _____ Cell: _____

If above person cannot be reached, please contact:

Name: _____ Relationship: _____

Phone number(s) where they can be reached during your work hours:

Phone: _____ Cell: _____

Medical Information

Health Care Provider/Doctor: _____ Phone: _____

Hospital Preference: _____

Other information/medical history which may be helpful in case of emergency:

_____

_____

_____

Care Alliance Health Center

Volunteer Program
Participant Profile and Acknowledgment
Last Updated June 2016

Handbook Acknowledgement

I, _____ certify that I have received and reviewed the Care Alliance Volunteer Program Handbook. I further understand that, by signing this statement as required, I am indicating that I have read the Volunteer Program Handbook and understand its contents, and have discussed questions I have with my supervisor or Care Alliance Volunteer Coordinator. I also realize that this statement will become a permanent part of my volunteer personnel file.

_____ _____

Participant signature **Date**

Media Authorization/Waiver

I authorize Care Alliance full and complete permission and any of its authorized agents or employees to:

(1) record my likeness, voice, story or quotation and/or property on a video, audio, photographic, digital, electronic or any other medium;
(2) use my name in connection with these recordings;
(3) use, reproduce, exhibit or distribute in any medium, including but not limited to print publications, television, video tapes, website, email updates, newsletters, outdoor advertising, these recordings for any purpose, including but not limited to public relations, fundraising, proposals to donors or introducing Care Alliance to the community.

In consideration of Care Alliance permitting me to volunteer, I release Care Alliance, its successors and assigns, agents and employees from any personal or proprietary right I may have in connection with such use. I understand that I have no right to control the use of my likeness, voice, story, quotation and/or property recorded by Care Alliance, and that I will not receive payment or any other compensation in connection with the use of the foregoing.

_____ _____

Participant signature **Date**

Affiliation Information

Complete the following section only if your placement involves course credit, payment from a third party (work experience), or other program requirements outside of a purely voluntary placement.

Affiliation: (*School, work experience program, etc.*)_____

This is a (check one):

☐ High school ☐ Technical school/career college ☐ College/university ☐ Work experience program

Contact person for affiliation (*externship coordinator, supervisor, etc.*)

Name: _____ Title: _____

Phone number: _____ Email: _____

Care Alliance
Health Center

Liability Waiver

By signing this agreement, I acknowledge that my participation at Care Alliance Health Center is completely voluntary and is being undertaken without promise or expectation of compensation.

In consideration of my being allowed to conduct activities as a volunteer, I, the undersigned, for myself, my legal representatives, heirs, and assigns, hereby release and discharge Care Alliance, an Ohio not-for-profit corporation, its employees, directors, officers, members, affiliates, associates, agents and any participating organizations, from any and all liability or for any claims for damages or injury I may incur resulting from my participation with Care Alliance. I understand that my participation involves risk of injury and illness, which may result directly or indirectly from my participation. I further state that I am and/or my child(ren) is(are) in proper condition for participating in these events. I agree to abide by the rules established by supervisors and staff relative to health and safety requirements.

Any dispute arising under this Waiver shall be submitted to conclusive, non-appealable, binding arbitration of the American Arbitration Association in Cleveland, Ohio pursuant to the rules of the Association.

_____ _____

Signature of Volunteer or Parent/Guardian (if under 18) Date

_____

Printed Name

CARE ALLIANCE HEALTH CENTER
POLICIES AND PROCEDURES

Section:	Technology	**Effective Date:**	6/29/2016
No:	T6203	**Supersedes Issue Date:**	N/A
Page:	1 of 4	**Re-evaluation Date:**	7/1/2019

TITLE: Use and Release of Patient Protected Health Information

POLICY:

1. Care Alliance will comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements for the use and disclosure of Protected Health Information (PHI).

2. CA will protect the confidentiality, integrity and availability of patient information belonging to our member's patients.

3. CA will protect that information in a manner that will comply with State and/or Federal privacy laws.

DEFINITIONS:

Covered Entity – A type of covered entity is a healthcare provider that conducts certain electronic transactions, including billing and eligibility information. Covered entities are also health plans, and healthcare clearing houses.

Business Associate – An individual or organization that is not part of a covered entity's workforce, who provides a service or performs a function for a covered entity which requires the use of PHI (ex. claims processing, data analysis, and/or practice management).

HIPAA – The Health Insurance Portability and Accountability Act, as defined in 45 CFR Parts 160, 162, and 164.

Inappropriate Disclosure – The release of information, transfer of information, provision of information, and access to or divulging patient information in any manner outside the entity holding the information that has not been authorized by the member or the member's patient.

Joint Venture – A legal arrangement between two or more entities to provide services, products or both.

Organized Healthcare Arrangement (OHCA) – An arrangement or relationship that allows two or more covered entities who participate in joint activities to share protected health information about individuals in order to manage and benefit their joint operations. OHCAs include utilization review decisions, which are studied by other participating covered entities, and quality improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf. OHCAs also include multiple entities holding themselves out to the public as participating in a joint enterprise and participating in joint activities. IPAs (Independent Practice Associations) that engage in utilization reviews, credentialing, and other health care operations are good examples.

Privacy Rule – The part of the HIPAA regulations that is related to the privacy of PHI. 45 CFR Subpart E outlines the Privacy Rule.

Designated Privacy Official – Care Alliance's Chief Operating Officer is the designated Privacy Official.

Protected Health Information (PHI) – Any information, including demographic information, that is created or received by a covered entity and relates to:

- The past, present, or future physical or mental health or condition of an individual
- The provision of healthcare to an individual
- The past, present, or future payment for the provision of healthcare to an individual, and that identifies the individual or there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information concerning a person that is living or deceased and may be in written, oral or electronic format. There are 18 identifiers that the Privacy regulation says can be used to identify a person including:
    1. Name
    2. All geographic subdivisions of a state, including street address, city, county, zip code, and zip code except for the first three digits in a zip code
    3. All dates directly related to the individual, including birth date, admission date, discharge date, date of death, (except for the year)
    4. Telephone number
    5. Fax number
    6. E-mail address
    7. Social Security Number
    8. Medical Record Number
    9. Health plan beneficiary number
    10. Account number
    11. Certificate/license number
    12. Vehicle identifiers and serial numbers
    13. Device identifiers and serial numbers
    14. URL addresses
    15. IP addresses
    16. Biometric identifiers, including fingerprints
    17. Full-face photographs and any comparable images
    18. Any unique identifying number, characteristic or code
- PHI excludes individually identifiable health information:
    1. In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g
    2. In records described at 20 U.S.C. 1232g(a)(4)(B)(iv)
    3. In employment records held by a covered entity in its role as employer
    4. Regarding a person who has been deceased for more than 50 years

PROCEDURE:

1. Requests for Individually Identifiable Information
    A. Requests for access to a patient's printed medical record or requests for electronic access to a patient's medical record will be referred to Patient Services Representative for processing.
    B. Requests will be responded to within 30 days.

2. Sensitive Information
    A. Certain information contained within medical records is particularly sensitive. For example, drug and alcohol treatment information, mental health records, Human Immunodeficiency Virus (HIV), and genetic testing information is particularly sensitive.
    B. The electronic medical record (EMR) may contain sensitive information as well as other treatment information that may require a special authorization before it can be released.
    C. The Privacy Officer, in conjunction with management staff, will determine which roles need access to PHI, including any sensitive information.
    D. Each user's security for access within the electronic medical record and practice management system will need to be set accordingly.

3. Confidentiality
    A. CA employees, contractors, students, volunteers, and interns must not discuss PHI with anyone unless it is directly required in order to perform their job duties.
    B. Conversations about confidential information should be conducted in a manner that preserves the confidentiality of the information.
    C. Confidential conversations should not be held in public spaces.
    D. Employees, students, interns, vendors and contractors must not access or review individual's health information contained in any of the databases or on paper for any reason other than to perform their job duties.

4. Confidentiality Agreements
    A. Employees, contractors, consultants, students and others must sign a confidentiality agreement as part of the conditions of their employment or their relationship with CA.

5. Privacy Training
    A. All CA employees, consultants, contractors, interns and students must complete CA confidentiality training.
    B. Confidentiality training will be completed as part of new employee orientation during the first week of employment, and at a minimum, annually thereafter.

6. Privacy Officer

Section:	Technology	**Effective Date:**	6/29/2016
No:	T6203	**Supersedes Issue Date:**	N/A
Page:	4 of 4	**Re-evaluation Date:**	7/1/2019

A. CA has designated the Chief Operating Officer as the Privacy Officer under the HIPAA Privacy regulation.
B. Questions regarding the privacy of member or patient information should be directed to the Privacy Officer for clarification.

This policy and procedure shall be reviewed every three years and updated consistent with the requirements and standards established by the Board of Directors and by Care Alliance management, Federal and State law and regulations, and applicable accrediting and review organizations.

CEO APPROVAL _____ DATE 6/29/16

BOARD APPROVAL _____ DATE 6/29/16

I have read the above and fully understand both the policy and the procedure. I have been given the opportunity to ask questions regarding this policy and fully understand and accept the consequences for failure to comply with this policy and procedure.

Signature Date

Print Name

DISCLOSURE AND AUTHORIZATION FORM
TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

Please Read Carefully Before Signing the Authorization

In considering you for employment and, if you are employed, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, Care Alliance Health Center ("the Company") may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

IntelliCorp Records, Inc. can be contacted by mail at 3000 Auburn Dr, Suite 410; Beachwood, OH 44122; or phone: 1-888-946-8355; or website: www.intellicorp.net.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and

- an "investigative consumer report" is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act ("FCRA").

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for employment purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

Care Alliance Health Center

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize ***CARE ALLIANCE HEALTH CENTER*** to obtain and rely upon consumer reports or investigative consumer reports concerning me. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in their decision about me.

I do _____do not_____ authorize you to contact *my current* employer for Employment and Reference Verifications

(This will authorize immediate inquiries to the Human Resources Department and to any listed supervisors or references in the Employment/Reference Section of your application.)

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____
Printed Name

_____ _____
Applicant Signature Date

_____ _____
Parent or Legal Guardian Signature (for searches conducted on minors under the age of 18) Date

INDIVIDUALS WHO ARE OR WILL BE EMPLOYED IN CALIFORNIA, MINNESOTA, AND OKLAHOMA

- ☐ **You may request a free copy of any consumer report or investigative consumer report we obtain on you by checking the box.**

INDIVIDUALS WHO ARE OR WILL BE EMPLOYED IN MASSACHUSETTS AND NEW JERSEY

- ☐ **By checking this box, you are acknowledging that you have been informed of your right to request a copy of the investigative consumer report we obtained on you and you are exercising your right to obtain a copy of that report.**

DISCLOSURE AND AUTHORIZATION FORM
TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

Please Read Carefully Before Signing the Authorization

Personal Data

Last Name _____ First Name _____ Middle Name _____

Current Address _____ Dates Lived Here _____

Addresses for the Past Seven Years: (include street, city, state, zip code) Dates of Residence:

_____ _____

_____ _____

_____ _____

Date of Birth _____ Other Names Used (including maiden name) _____ Years Used _____

Social Security Number _____ Driver's License # _____ State _____

Email address (may be used for official correspondence) _____

I have the right to make a request to **IntelliCorp Records, Inc.**, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including sources of information, and the recipients of any reports on me which **IntelliCorp Records, Inc.** has previously furnished within the two-year period preceding my request.

Printed Name _____ Applicant Signature _____ Date _____

Care Alliance Health Center

NATIONAL PRACTITIONER DATA BANK QUERY (NPDB)

Print all information clearly:

Date: _____ ☐ One time Query ☐ Continuous Query

Last Name: _____ First Name _____ Middle Initial _____

Other Name(s) Used: _____ Gender ☐ M ☐ F DOB: ____ - ____ - ____

_____ SS# ____ - ____ - ____

Current Position: Check

☐ Behavioral Health	☐ HIV Services	☐ Outreach Workers
☐ Community Engagement	☐ Hygienists	☐ PSR
☐ Care Coordination	☐ Medical Assistants	☐ Pharmacy
☐ Dental Assistants	☐ Registered Nurse	☐ Other

Education / Professional and or Certification / License:

Professional School_____

Grad Year_____

License or Certification_____ or ☐ No License

State_____ Degree/Title_____

Speciality_____

Care Alliance Health Center

FITNESS FOR DUTY DISCLOSURE

Answer all questions. Any "Yes" response requires a written explanation (**attach separate sheet**).
If an answer is **non-applicable**, please check the "**NO**" box.

	Y	N	
1.	☐	☐	Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
2.	☐	☐	Has there been any challenge to your licensure, registration or certification?
3.	☐	☐	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board?
4.	☐	☐	Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
5.	☐	☐	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
6.	☐	☐	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
7.	☐	☐	Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
8.	☐	☐	Have any of your board certifications or eligibility ever been revoked?
9.	☐	☐	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?
10.	☐	☐	Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

Care Alliance Health Center

FITNESS FOR DUTY DISCLOSURE

	Y	N	
11.	☐	☐	Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?
12.	☐	☐	Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
13.	☐	☐	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
14.	☐	☐	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?
15	☐	☐	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
16.	☐	☐	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?
17.	☐	☐	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
18.	☐	☐	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
19.	☐	☐	Have you ever had any professional liability actions (pending, settled, arbitrated, mediated or litigated)?
20.	☐	☐	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
21.	☐	☐	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
22.	☐	☐	Have you ever been court-martialed for actions related to your duties as a medical professional?

Care Alliance Health Center

FITNESS FOR DUTY DISCLOSURE

	Y	N	
23.	☐	☐	Are you currently engaged in the illegal use of drugs?
24.	☐	☐	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
25.	☐	☐	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
26.	☐	☐	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

I hereby affirm that the information submitted above is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions, or misrepresentations may result in denial of my application or termination of my privileges, employment, or participation agreement, as applicable.

Print Name _____ Signature _____

Date _____

Confirming Authority Name (Print):

Title _____ Signature _____

Date _____

CONCENTRA
5500 South Marginal Road
Cleveland OH 44103
Phone: 216-426-9020 ~ Fax: 216-426-9025

REFERRAL FORM

Company Name: **Care Alliance Health Center** Date: / /

Employee :
Last Name First:

Authorization: Marilyn Matlock English
Company Representative – Please sign

PURPOSE:

This employee is being referred to you for:

☒ Post ☐ Annual ☐ Return to Work ☐ Random ☐ _____ ☐ _____

SPECIFICATION:

☐ Federal (Regulated) ☐ Non-Federal (Non-Regulated)

SERVICE: (Check all that apply)

☐	Pre-Placement/Post Offer Physical Exam	☐	New Injury Treatment
☐	DOT Physical Examination	☐	Follow-up Injury Care
☐	Non-Federal Urine Drug Screen	☐	DOT Urine Drug Screen
☐	Non-Federal Breath Alcohol Test	☐	DOT Breath Alcohol Test
☐	Instant Drug Screen	☐	Fitness for Duty Examination
☐	Respiratory Clearance Examination	☐	Asbestos / Hazmat Exam

☒ Other (Please Specify): **Hepatitis B (if required by employee)**

REQUIREMENTS:

Photo Identification is required for all services. New injury treatment, urine drug screening and breath alcohol tests are accepted any time during business hours.

Concentra Hours:

Monday thru Friday 7:00 AM – 7:00 PM