



**Employee Health & Wellness  
Service Approval Form**

This form is to be completed by the department manager/supervisor and brought to Employee Health & Wellness at the time of service, or faxed to 706/721-0882 prior to services being rendered.

Employee/Faculty Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_ Date of Service: \_\_\_\_\_

**Please mark all services to be performed during this visit:**

√	<i>Services</i>	√	<i>Immunizations</i>
	Post Hire Physical (includes tuberculosis screening, respiratory fit testing, MD clearance, immunization titers, urine drug screen)		Hepatitis B Vaccine Series w/ Follow-up Titers
	Employee Health & Wellness Risk Assessment (LAS only)		Quantiferon Gold Testing (or) TSpot
	Annual Health Screen (Tuberculosis screening, respiratory fit testing, Employee Health & Wellness risk assessment- <b>non LAS</b> )		MMR Vaccine
	Urine Drug Screen		Varicella (Varivax) Vaccine
	Immunization Titers		Hepatitis A Vaccine
	Respiratory Physical		Rabies Vaccine
	Respiratory Fit Testing only		Tdap Vaccine
	TB Skin Test		Tetanus Vaccine
	Physician Visit only		Influenza Vaccine

**By signing below I authorize payment for the above marked services. The department has approved payment for these services, and an invoice will be sent to the cost center listed below.**

Department Name \_\_\_\_\_

Cost Center NUMBER to be billed \_\_\_\_\_

Print name of manager/supervisor approving services \_\_\_\_\_

Signature of manager/supervisor approving \_\_\_\_\_

Address & Phone # of Augusta University Department \_\_\_\_\_

**Employee Health & Wellness 706/721-3418 Fax Number: 706/721-0882**

**Email: [EmployeeHealth@augusta.edu](mailto:EmployeeHealth@augusta.edu)**

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