

# Plumas County Public Health Agency

## Employee Health Screening Billing Authorization Form

**To be completed by employee:**

Name: \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_

County Agency/Department: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COUNTY/AGENCY DATA****To be completed by supervisor:**

Department Number: \_\_\_\_\_ Agency: \_\_\_\_\_ Bill Code: \_\_\_\_\_ Job Category: \_\_\_\_\_  
\_\_\_\_\_

Department Name: \_\_\_\_\_ Job Description: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Work Location: \_\_\_\_\_

Animal Control: \_\_\_\_\_ Hazardous Materials: \_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

Authorized By: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by HR:**

REASON FOR SERVICE: \_\_\_\_\_ New Employee \_\_\_\_\_ Employee Number: \_\_\_\_\_

Scheduled Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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