Cornell University

Cornell Health
**Occupational Medicine**
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# DEPARTMENT CHARGE AUTHORIZATION

**Instructions**

Please complete this form (including authorized signature). You may present it when you check in for your Cornell Health appointment, or you may FAX it prior to your appointment to Cornell Health Occupational Medicine at 607.255.6149.

If you are submitting on behalf of a group of employees, you may use one form and attach a list of employee names and Cornell ID numbers.

**Patient Information**

Name (*please print*) _____

Cornell ID # _____ Phone # _____

Type of visit (check one)

- ☐ Physical
- ☐ Immunization
- ☐ Surveillance – Procedure
- ☐ Travel consultation / Immunizations
- ☐ Bulk Supplies (quantity / type requested)

**Account Information**

Department / Program _____

Account # _____

Business Service Center (BSC) Representative _____

Phone # _____

**Authorized Signature** (supervisor, department chair, etc.)

I have verified the listed account number and approve payment of charges for the above patient. I will keep a copy of this form for my records or forward as backup to my BSC representative.

Name (*please print*) _____ Title _____

Signature _____ Date _____