



**WORK ORDER
ILL-AT-WORK
EMPLOYEE MEDICAL EXAMINATION**

Employee Information	
Last Name	
First Name	
Birthdate	
Home Address	
Employee Number	
Employee's Job Title	
Department Information	
Department Name & Number	
Work Order Number	
Work Order Date	
Person Completing Work Order	
Phone Number & Email Address	
Appointment Information	
Appointment Date and Time	
Occupational Health Clinic Name	
Clinic Address	
Clinic Phone Number	

***Give a copy of the completed Work Order to the employee
and scan a copy of the work order to OHP@hr.lacounty.gov***