



Company			
Physical Address	City	State	Zip
Billing Address	City	State	Zip
Contact	Contact Email		
Phone	Extension	Fax	

Bill company: Physical Drug/Alcohol Test Injury Miscellaneous

Bill Other: _____

Drug Screen <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Please indicate if we have the Custody and Control Form (CCF) at our facility or if the Employee will be carrying it in. If unsure, please call.</p> <p><input type="checkbox"/> CCF at facility / In-House Account <input type="checkbox"/> CCF to be carried by Employee</p>
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Substance Abuse Testing Note: Testing is conducted between 7:00 am and 5:00 pm (varies by location)

<input type="checkbox"/> Instant Drug Screen: <input type="checkbox"/> 5 Panel <input type="checkbox"/> 7 Panel <input type="checkbox"/> 10 Panel	Reason for Test(s): <input type="checkbox"/> Pre-employment <input type="checkbox"/> Follow-up <input type="checkbox"/> Post-accident <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Return to Duty <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Non-DOT Drug Test: <input type="checkbox"/> 5 Panel <input type="checkbox"/> 7 Panel <input type="checkbox"/> 10 Panel	
<input type="checkbox"/> DOT Drug Screen <input type="checkbox"/> Random	
<input type="checkbox"/> Breath Alcohol Testing	
<input type="checkbox"/> Hair Drug Screen <input type="checkbox"/> 5 Panel <input type="checkbox"/> 7 Panel <input type="checkbox"/> 10 Panel	
<input type="checkbox"/> Chain of Custody Alteration	
<input type="checkbox"/> Collection Only	

Report Results: Mail Fax Email Phone

MRO (for collection only)

MRO name			
Address	City	State	Zip
Phone	Fax		
Lab	Account No.		

TPA (Third Party Administrator)

TPA or Lab			
Billing Address	City	State	Zip
Phone	Fax		

Physicals <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><input type="checkbox"/> DOT Physical <input type="checkbox"/> Employment Physical Level 2 <input type="checkbox"/> Employment Physical Level 1 <input type="checkbox"/> Respirator Clearance Physical <input type="checkbox"/> Nurse Visit <input type="checkbox"/> Asbestos / Lead Exposure Exam <input type="checkbox"/> Health Assessment Exam</p> <p>If yes, please indicate which services may be accompanying this physical.</p> <p><input type="checkbox"/> Immunizations _____ <input type="checkbox"/> Vision <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Spirometry / PFT <input type="checkbox"/> EKG <input type="checkbox"/> Audiograms <input type="checkbox"/> View 1 <input type="checkbox"/> Respirator Fit <input type="checkbox"/> Krause Weber Back <input type="checkbox"/> View 2 <input type="checkbox"/> Blood Work _____ <input type="checkbox"/> Respirator Clearance <input type="checkbox"/> B Reader <input type="checkbox"/> Other _____</p>
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