Omega Medical Center
Your Occupational Health Resource
D.O.H.R., L.L.C.

Services Required

Patient must bring photo identification along with original authorization form.

Date: _____

Employee Name:_____

Social Security #:_____

Company Name: _____

PHYSICAL:

____PRE-EMPLOYMENT
____General
____Respirator
____Complex

____ANNUAL
____DOT
____HAZMAT
____Other (Specify)

DRUG SCREEN:

Reason for test:

____Pre-employment
____Random
____Post-Accident
____Reasonable Suspicion
____Return to Duty
____Follow-up
____Other (Specify)

Drug Screen Type:

____Collection
____Company Panel
____DOT Nida
____Dupont/Contractors
____DOT Nida Consortium
____Other - Specify

Alcohol:

____Urine
____BAT (Breathalyzer)
____Blood

Miscellaneous:

____Injury – Date of Injury_____
____Return to Work
____Respirator Fitness Test
____Respirator Fitness Test with Class B x-ray
____Other_____

Authorized by (Signature)_____Title:_____

Phone: (_____)_____ Date:_____