Occupational
Medicine

Employer Protocol Account Form

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 ☐ Yes ☐ No	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. ☐ CCF at facility / In-House Account ☐ CCF to be carried by Employee

Substance Abuse Testing Note: Testing is conducted between 7:00 am and 5:00 pm (varies by location)

☐ Instant Drug Screen: ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel
☐ Non-DOT Drug Test: ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel
☐ DOT Drug Screen ☐ Random
☐ Breath Alcohol Testing
☐ Hair Drug Screen ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel
☐ Chain of Custody Alteration
☐ Collection Only

Reason for Test(s):
☐ Pre-employment ☐ Follow-up
☐ Post-accident
☐ Reasonable Suspicion/Cause ☐ Return to Duty
☐ Other (specify):_____

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 ☐ Yes ☐ No	☐ DOT Physical ☐ Employment Physical Level 1 ☐ Employment Physical Level 2 ☐ Nurse Visit ☐ Respirator Clearance Physical ☐ Health Assessment Exam ☐ Asbestos / Lead Exposure Exam If yes, please indicate which services may be accompanying this physical. ☐ Immunizations_____ ☐ Vision ☐ Chest X-ray ☐ Spirometry / PFT ☐ EKG ☐ Audiograms ☐ View 1 ☐ Respirator Fit ☐ Krause Weber Back ☐ View 2 ☐ Blood Work_____ ☐ Respirator Clearance ☐ B Reader ☐ Other_____

Injury Care ☐ Yes ☐ No	Carrier Information: ☐ Modified Duty ☐ No Modified Duty ☐ Call for instruction ☐ LNI ☐ Self-Insured Self-Insured Carrier Information:

Other Services ☐ Yes ☐ No	Please indicate if your employees need additional services:		
	☐ Hep B	☐ TDap	☐ Lipid Profile
	☐ Varicella	☐ Flu	☐ CBC
	☐ MMR	☐ TB	☐ Tetanus (TD)
	☐ Titers	☐ Lead	☐ Other

If you have further instructions, please add them here:_____

_____

_____

Completed by:_____ Date Submitted:_____

If you have any questions, please call **509.793.9781** or email: **occmed@samaritanhealthcare.com**