



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 ANNUAL

 General DOT
 Respirator HAZMAT
 Complex Other (Specify)

DRUG SCREEN:
Reason for test: Pre-employment Return to Duty
 Random Follow-up
 Post-Accident Other (Specify)
 Reasonable Suspicion

Drug Screen Type: Collection Dupont/Contractors
 Company Panel DOT Nida Consortium
 DOT Nida 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: _____