

<b>Section A: Employer Information</b>			<b>Section B: Physical Examination</b>			<b>Section C: Urine Drug/Alcohol Tests</b>		
Employer Name:			Donor will bring Physical Exam Form <input type="radio"/> Yes <input type="radio"/> No			Urine Drug Screens		
Address:			<input type="radio"/> DOT Physical Exam			<input type="radio"/> Collection Only / Donor will bring COC		
Phone #			<b>These Additional Services MAY BE Required</b>  Will Employer pay for the additional Services ?  <div style="text-align: center;"><input type="radio"/> Yes    <input type="radio"/> No</div> <input type="radio"/> Spirometry – Pulmonary Function <input type="radio"/> Audiometry <input type="radio"/> Vision Test - Keystone <input type="radio"/> Glucose Finger Stick <input type="radio"/> Electrocardiogram (EKG)			<b>Florida Drug Free Workplace</b>		
Fax #						<input type="radio"/> 5 Panel HRS		
						<input type="radio"/> 8 Panel HRS		
						<input type="radio"/> 10 Panel HRS		
						<b>DOT</b>		
<b>Third Party Administrator</b>						<input type="radio"/> DOT / NIDA		
Name:						<b>Alcohol Testing</b>		
Address:						<b>Lake Ella, Appleyard, North &amp; Mahan Locations Only</b>		
Phone #						<input type="radio"/> DOT Breath Alcohol Test		
Fax #						<input type="radio"/> Non – DOT Breath Alcohol Test		
						<b>Additional Comments/ Notes:</b>		
<b>Section D: Authorization Information</b>								
Print Name of Authorizer:			Authorizer Signature:			Phone #		
			Title:			Date:		
Fax or Mail results to:			<b>Billing: Please mark responsible billing party</b>			<b>For Patients First Use Only:</b> Phone Auth received by:		
			<input type="radio"/> Bill Employer			Date & Time		
			<input type="radio"/> Bill Third Party Administrator					