

Employer Intake Form

New Employer <input type="checkbox"/> Updates <input type="checkbox"/>

SECTION I – EMPLOYER

1. Legal Name		2. DBA (if applicable)	
3. Physical Address		4. City	5. State
		6. ZIP	
7. Phone		8. FAX	
9. Main Contact	10. Job Title	11. Email	
12. Direct Phone		13. Direct Fax	
14. Second Contact (if needed)	15. Job title	16. Email	
17. Direct Phone		18. Direct Fax	

SECTION II – DRUG SCREENS

<input type="checkbox"/> Instant (Rapid Results)	
<input type="checkbox"/> DOT Drivers Drug Test	
<input type="checkbox"/> SOMG Lab	<input type="checkbox"/> Employer's Lab
<input type="checkbox"/> NON-Dot Drug Test	
<input type="checkbox"/> SOMG Lab	<input type="checkbox"/> Employer's Lab
<input type="checkbox"/> Breath Alcohol Testing	
<input type="checkbox"/> Hair Collection	

SECTION III – SERVICES (Check all that apply)

<i>Physicals</i>	<i>Specific Testing</i>
<input type="checkbox"/> DOT Exam	<input type="checkbox"/> Audiogram
<input type="checkbox"/> Pre-Placement Exam	<input type="checkbox"/> Pulmonary Function Test
<input type="checkbox"/> Hazmat Exam	<input type="checkbox"/> Respirator Fit Test
<input type="checkbox"/> Respiratory Exam	<input type="checkbox"/> Lift Test
<input type="checkbox"/> Return To Work Exam	<input type="checkbox"/> EKG
	<input type="checkbox"/> Other:

Vaccinations

<input type="checkbox"/> TB Test PPD
<input type="checkbox"/> Tetanus Vaccination
<input type="checkbox"/> Hepatitis B Vaccination
<input type="checkbox"/> Flu Shot

Lab Testing

<input type="checkbox"/> MMR Titer	<input type="checkbox"/> Lead, Blood
<input type="checkbox"/> Hep B Titer	<input type="checkbox"/> Chemistry Panel, Blood
<input type="checkbox"/> Varicella Titer	<input type="checkbox"/> CBC, Blood

SECTION V – CHECK-OUT – Send Results By:

<input type="checkbox"/> Email:	<input type="checkbox"/> Fax:
<input type="checkbox"/> Mail:	<input type="checkbox"/> Other: