



Company Profile – Protocol

OMC Occupational Health Services office use only:
Company Guarantor Number:
MEDTOX Acct Number:

Today's Date: _____

COMPANY INFORMATION

Company Name: _____
 Parent Corporation: _____
 US DOT#: _____

Address: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

Billing Address (If different than above):
 Address: _____
 City: _____ State: _____ Zip Code: _____

COMPANY AUTHORIZED CONTACTS

Primary Contact Name: _____ Phone: _____ Ext: _____
 Email: _____ Fax: _____

Secondary Contact Name: _____ Phone: _____ Ext: _____
 Email: _____ Fax: _____

(Additional contacts if different than above)
 Billing Contact Name: _____ Phone: _____ Ext: _____
 Email: _____ Fax: _____

Drug/Alcohol Contact Name: _____ Phone: _____ Ext: _____
 Email: _____ Fax: _____

Workers Comp Contact Name: _____ Phone: _____ Ext: _____
 Email: _____ Fax: _____

INJURY CARE/WORKERS COMPENSATION (Work comp accounts will only be set up in the event of an injury.)

Workers Compensation Insurance Carrier: _____

Drug Test on Initial Injury Visit? Yes No
 Breath Alcohol Test (BAT) On Initial Injury Visit? Yes No
 (Positive BAT for Non-DOT will confirm with a blood alcohol test.)

Light Duty Available? Yes No
 Would you like us to fax or email the Medical Report to Employer? Yes No

Special Instructions: _____

Additional information or comments: _____

REQUESTED SERVICES

PHYSICAL EXAMS (Check what physical exams your company is requesting.)

Drug screens are not automatically part of the physical exam process, if a drug screen is needed, please request it separately.

- DOT
- FAA
- OSHA Surveillance (Please list what type(s) of Surveillance.): _____
- Performance Evaluation/Work Capacity (Must supply own function test evaluation form) performed in our Rehabilitation Services department.
- Other (Please explain.): _____
- Work Injury
- Tuberculosis
- Pre-Placement (Job descriptions may be requested.)
- Return to Work

DRUG AND ALCOHOL TESTING SERVICES (Check what services your company is requesting.)

- Option 1: Collection Only** (Using your company paperwork, lab, and MRO)
 - Federal (DOT, HHS, NRC) Non-DOT/Non-Federal
 - Donor will bring Chain of Custody (COC) form. Company or lab will send a supply of COCs to OMC.
- Option 2: Full Service** (Olmsted Medical Center's contracted lab, MRO, and results sent to your company.)
 - Federal (DOT, HHS, NRC). If DOT, specify DOT Agency: FMCSA FTA FAA FRA PHMSA USCG
 - Rapid Urine Drug Screen Non-DOT/Non-Federal (Default)
 - 5 Panel (Default) 11 Panel 6 Panel (No THC)

ALCOHOL TESTING

- Federal/DOT Breath Alcohol Test (BAT)
- Non-DOT Breath Alcohol Test (BAT) (Positive BAT for Non-DOT will be confirmed with a blood alcohol test.)
- Blood Alcohol Test (BAT)

(This section is only if you want your company to be added to Olmsted Medical Center's Random Program.)

Random Drug / Alcohol Testing Program:

- Federal DOT Random Drug and Alcohol Testing:
 - FMCSA (Federal Motor Carrier Safety Administration) FTA (Federal Transit Administration)
- Non-Federal/Non-DOT Random Drug and Alcohol Testing

For Random Drug and Alcohol Testing Programs, please attach a list of employees' names, driver's license numbers and the last 4 of their SSNs.

OTHER SERVICES (Check what services your company is requesting.)

- Audio Screen
- Chest X-ray (Requires physical exam.)
- OSHA Labs (Lead, Arsenic, Cadmium, Mercury)
- Quantiferon TB
- Respiratory Form Review
- Respiratory Fit Test (Qualitative)
- Pulmonary Function Test/Spirometry
- TST/PPD (Tuberculosis skin test)
- Hepatitis A Vaccine
- Hepatitis B Vaccine
- Influenza (Flu) Vaccine
- MMR Vaccine
- Rabies Vaccine
- TD or TDaP Vaccine
- Varicella Vaccine
- Other Services Not Listed. (Please specify.): _____
- Hepatitis A Titer
- Hepatitis B Titer
- Hepatitis C Titer
- MMR Titer
- Rabies Titer
- Varicella Titer

RESULTS (Please indicate where you would like exam and test results sent.)

Encrypted Email or Secure Fax

Email Address: _____

Secure Fax#: _____ (Fax machine is maintained in a manner that ensures privacy by restricting access to authorized personnel only.)

Contact Person: _____ Phone: _____

Additional information or comments: _____

Form Completed by: _____

**Please email completed form to occhealth@olmmed.org.
Email is preferred, but you can also fax the completed form to 507.292.7001.**