

(Applicant / Employee must present photo ID)

Fossil Creek South Fort Worth

Name _____ SSN _____ DOB _____

EmployerLocation/Branch _____

WORK RELATED INJURY/ILLNESS CARE D/O/I _____

Causation of Injury/Illness _____

SUBSTANCE ABUSE TESTING

DOT Drug Screen

FMCSA PHMSA Other _____

NON-DOT DRUG SCREEN (LAB TESTING)

Collection only Urine Hair

Hair Follicle # _____

Finger/Toe Nail Testing # _____

STAT DRUG SCREEN

5 panel 9 panel Custom panel _____

BREATH ALCOHOL TESTING

DOT Non-DOT

REASON FOR TESTING

- Post Offer
- Post-Accident
- Random
- Reasonable Cause
- Follow up
- Other

DOT MEDICAL EXAMINATION

New Hire Re-Certification

Return to Work / Fit for Duty

PHYSICAL EXAMINATIONS

- Post Offer
- Return to Work / Fit for Duty
- Exit
- Annual

MEDICAL SURVEILLANCE

- Respirator Medical Certification
- Crystalline Silica Examination
- Asbestos Examination
- Underwater Diver Examination
- HAZMAT / HAZWOPER
- Audiogram
- Lead/ZPP
- Other _____

ABILITY TEST / WORKSTEPS

Position _____

OTHER TESTING

- Respirator Mask Fit Testing only
Model(s) _____
- Pulmonary Function Test (PFT) only
- PPD (TB skin test / 2 steps)
- TB Spot (TB blood test / 1 step)
- Chest X-ray
- Hep A Hep B Rabies Tetanus
- Special Request _____

Instructions/Comments _____

No children allowed in testing areas. Please make arrangements.

Applicant to Pay Bill Workers' Comp Bill Employer

Authorized _____
Print name *Signature*

Phone _____ E-mail _____ Date _____

Download the form to your desktop, fill it out with Acrobat Reader, and select **SUBMIT** to send electronically or print out and fax to numbers below:

Fossil Creek Clinic
3645 Western Center Blvd.
Fort Worth, Texas 76137
(817) 306-9200
(817) 306-0329 Fax

SUBMIT

Give us a call with questions or problems with the form.

South Fort Worth Clinic
4775 South Freeway at Felix
Fort Worth, Texas 76115
(817) 921-2500
(817) 921-0625 Fax