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Employee Name: _____ **Date:** _____

Company: _____ **Contact Name:** _____

Social Security #: _____ **Job Number:** _____

Injury Treatment: Type: _____

Physical Exam:

<input type="checkbox"/> DOT	<input type="checkbox"/> Non-DOT	<input type="checkbox"/> HAZMAT	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Operator
<input type="checkbox"/> Pre-Placement	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Re-Certification	<input type="checkbox"/> Other _____

Physical Performance Test: Pre-Placement Other _____

Breath Alcohol: DOT Non-DOT

Drug Screen:

<input type="checkbox"/> Quick (Urine)	<input type="checkbox"/> Non-DOT (Urine)	<input type="checkbox"/> DOT (Urine)	
<input type="checkbox"/> 5 Panel	<input type="checkbox"/> Pre-Placement	<input type="checkbox"/> FMSCA	<input type="checkbox"/> Other: _____
<input type="checkbox"/> 10 Panel	<input type="checkbox"/> Random	<input type="checkbox"/> PHMSA	<input type="checkbox"/> Other: _____
<input type="checkbox"/> 12 Panel	<input type="checkbox"/> Post-Accident	<input type="checkbox"/> USCG	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Synthetic Marijuana		<input type="checkbox"/> Synthetic Opioid	

Hair Test: **Prime Hair Test (5 Panel)** **Other** _____

DISA:

<input type="checkbox"/> Pre-Placement	<input type="checkbox"/> BAT (Non-DOT)	<input type="checkbox"/> BAT (DOT)
<input type="checkbox"/> Random	<input type="checkbox"/> Urine (Not-DOT)	<input type="checkbox"/> Urine (DOT)
<input type="checkbox"/> Post Accident	<input type="checkbox"/> FMCSA	<input type="checkbox"/> PHMSA
	<input type="checkbox"/> Hair	<input type="checkbox"/> USCG
		<input type="checkbox"/> DISA Policy/Account: _____

Respirator Fit Test: Qualitative Quantitative (PortaCount)

Mask #1: _____ Mask #2: _____ Mask #3: _____

Pulmonary Function Test **Medical Record Evaluation**

Audiogram (add STS Comparison? Yes No) **Titmus Vision Testing**

Return to Work Clearance **Fit for Duty Clearance**

Safety Evaluation

TB Skin Test (Employee must be able to return to the clinic within 2 days to have test read)

Laboratory Tests: _____

Other: _____

Authorized Signature

(____)_____-_____
Phone Number