Nursing and Occupational Testing Services Request Form

PERSON REQUESTING SERVICES	TITLE	DATE	TIME

Drug/Alcohol/COVID (check all that apply)

- ☐ Non-DOT Drug Testing (Lab)
- ☐ Non-DOT Drug Testing (Rapid)
- ☐ DOT Drug Testing (Lab)
- ☐ DOT Drug Testing (Rapid)
- ☐ Alcohol Testing
- ☐ New Hire ☐ Random ☐ For Cause
- ☐ Accepting Other Drug Cards? ☐ Yes ☐ No
- ☐ COVID-19 Testing

Respiratory/Fit (check all that apply)

- ☐ Respiratory Medical Evaluation Online
- ☐ Respiratory Medical Evaluation Onsite
- ☐ Qualitative Fit Test

Respirator Type – _____

- ☐ Quantitative Fit Test

Respirator Type – _____

- ☐ Blood Lead In
- ☐ Blood Lead Out

Onsite Nurses

Start Date: _____ End Date: _____

Shift/Hours: _____ Days of the week: _____

ADDITIONAL DETAILS: _____

SIGNATURE OF CONTACT PERSON: _____ DATE: _____

SIGNATURE OF CONTACT PERSON: _____ DATE: _____

SIGNATURE OF EHSS REPRESENTATIVE: _____ DATE: _____

***EHSS Representative to sign and return after services are complete. ***

COMPANY NAME - _____ **NAME OF JOBSITE LOCATION -** _____

JOBSITE ADDRESS - _____

CONTACT PERSON - _____ **CONTACT PERSON PHONE NUMBER -** _____

CONTACT PERSON EMAIL - _____

APPROXIMATE NUMBER OF EMPLOYEES - _____

REQUEST DATE AND TIME OF SERVICE - _____ **ACTUAL NUMBER -** _____

SEND DRUG AND ALCOHOL OR COVID RESULTS TO - _____

SEND MEDICAL EVALUATION RESULTS TO - _____

SEND FIT TEST RESULTS TO - _____

IS CHAIN OF CUSTONDY NEEDED - _____

JOB# AND COST CODE - _____ **PURCHASE ORDER -** _____

EMAIL INVOICES TO THE FOLLOWING - _____

SIGNATURE: _____ **DATE:** _____

Ask us about 100/0® Safety Culture today!

***CLICK ON SUBMIT BUTTON TO DELIVER: Submit

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