Nursing and Occupational Testing Services Request Form

*Complete and send to: m.koon@ehs-solution.com
kristi@ehs-solution.com

PERSON REQUESTING SERVICES	TITLE	DATE	TIME

Drug/Alcohol

Check the Appropriate Box(s)

- ☐ 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

Respiratory/Fit

Check Click the Appropriate Box(s)

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

Respiratory Type -

- ☐ Quantitative Fit Test

Respiratory Type –

- ☐ Blood Lead In
- ☐ Blood Lead Out

Onsite Nurses

Start Date: End Date:

Shift/Hours:

SIGNATURE OF CONTACT PERSON: _____ DATE:

COMPANY NAME -

JOB # AND COST CODE -

PURCHASE ORDER -

E-MAIL INVOICES TO THE FOLLOWING -

JOBSITE LOCATION -

CONTACT PERSON -

CONTACT PERSON PHONE NUMBER -

CONTACT PERSON EMAIL -

APPROXIMATE NUMBER OF EMPLOYEES - **ACTUAL NUMBER -**

REQUESTED DATE AND TIME OF SERVICE -

SEND DRUG AND ALCOHOL RESULTS TO -

SEND MEDICAL EVALUATION RESULTS TO -

SEND FIT TEST RESULTS TO -

IS THE CHAIN OF CUSTODY NEEDED?-