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/COVID

Double Click 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
- ☐ COVID-19 Testing

Respiratory/Fit

Double 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:

ADDITIONAL DETAILS: :_One day per week _____

SIGNATURE OF CONTACT PERSON: _____DATE:_____

SIGNATURE OF CONTACT PERSON: _____DATE: _____

SIGNATURE OF EHSS REPRESENTATIVE: _____DATE: _____

***EHSS Representative to sign and return after service is complete.**

COMPANY NAME -

NAME OF JOBSITE LOCATION-

JOBSITE ADDRESS-

CONTACT PERSON-

CONTACT PERSON PHONE NUMBER-

CONTACT PERSON EMAIL-

APPROXIMATE NUMBER OF EMPLOYEES-

REQUESTED 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 CUSTODY NEEDED-

JOB # AND COST CODE-

PURCHASE ORDER-

EMAIL INVOICES TO THE FOLLOWING-

SIGNATURE: _____ **DATE:** _____