OLMSTED MEDICAL CENTER

Company Profile – Protocol

OMC Occupational Health Services office use only:
Company Guarantor Number:
MEDTOX Acct Number:

Today's Date: _____

COMPANY INFORMATION

Company Name: _____
Parent Corporation: _____
US DOT#: _____

Address: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Billing Address (If different than above):
Address: _____
City: _____ State: _____ Zip Code: _____

COMPANY AUTHORIZED CONTACTS

Primary Contact Name: _____ Phone: _____ Ext: _____
Email: _____ Fax: _____

Secondary Contact Name: _____ Phone: _____ Ext: _____
Email: _____ Fax: _____

(Additional contacts if different than above)
Billing Contact Name: _____ Phone: _____ Ext: _____
Email: _____ Fax: _____

Drug/Alcohol Contact Name: _____ Phone: _____ Ext: _____
Email: _____ Fax: _____

Workers Comp Contact Name: _____ Phone: _____ Ext: _____
Email: _____ Fax: _____

INJURY CARE/WORKERS COMPENSATION (Work comp accounts will only be set up in the event of an injury.)
Workers Compensation Insurance Carrier: _____

Drug Test on Initial Visit? ☐ Yes ☐ No
Breath Alcohol Test (BAT) On Initial Visit? ☐ Yes ☐ No
(Positive BAT for Non-DOT will confirm with a blood alcohol test.)

Light Duty Available? ☐ Yes ☐ No
Would you like us to fax the Medical Report to Employer? ☐ Yes ☐ No

Special Instructions: _____

Additional information or comments: _____

REQUESTED SERVICES

PHYSICAL EXAMS (Check what physical exams your company is requesting.)
Drug screens are not automatically part of the physical exam process, if a drug screen is needed, please request it separately.

☐ DOT ☐ Work Injury ☐ Pre-Placement (Job descriptions may be requested.)
☐ FAA ☐ Tuberculosis ☐ Return to Work
☐ OSHA Surveillance (Please list what type(s) of Surveillance.): _____
☐ Performance Evaluation/Work Capacity (Must supply own function test evaluation form) performed in our Rehabilitation Services department.
☐ Other (Please explain.): _____

DRUG AND ALCOHOL TESTING SERVICES (Check what services your company is requesting.)

☐ **Option 1: Collection Only** (Using your company paperwork, lab, and MRO)
☐ Federal (DOT, HHS, NRC) ☐ Non-DOT/Non-Federal
☐ Donor will bring Chain of Custody (COC) form. ☐ Company or lab will send a supply of COCs to OMC.

☐ **Option 2: Full Service** (Olmsted Medical Center's contracted lab, MRO, and results sent to your company.)
☐ Federal (DOT, HHS, NRC). If DOT, specify DOT Agency: ☐ FMCSA ☐ FTA ☐ FAA ☐FRA ☐ PHMSA ☐USCG
☐ Rapid Urine Drug Screen Non-DOT/Non-Federal (Default)
☐ 5 Panel (Default) ☐ 11 Panel
☐ Standard Urine Drug Screen (lab send in)
☐ 5 Panel (Default) ☐ 7 Panel ☐ 10 Panel
If specific drugs need to be tested, please list them here: _____

ALCOHOL TESTING
☐ Federal/DOT Breath Alcohol Test (BAT)
☐ Non-DOT Breath Alcohol Test (BAT) (Positive BAT for Non-DOT will be confirmed with a blood alcohol test.)
☐ Blood Alcohol Test (BAT)

(This section is only if you want your company to be added to Olmsted Medical Center's Random Program.)
Random Drug / Alcohol Testing Program:
☐ Federal DOT Random Drug and Alcohol Testing:
☐ FMCSA (Federal Motor Carrier Safety Administration) ☐ FTA (Federal Transit Administration)
☐ Non-Federal/Non-DOT Random Drug and Alcohol Testing
For Random Drug and Alcohol Testing Programs, please attach a list of employees' names and their SSNs.

OTHER SERVICES (Check what services your company is requesting.)

☐ Audio Screen	☐ Hepatitis A Vaccine	☐ Hepatitis A Titer
☐ Chest X-ray (Requires physical exam.)	☐ Hepatitis B Vaccine	☐ Hepatitis B Titer
☐ OSHA Labs (Lead, Arsenic, Cadmium, Mercury)	☐ Influenza (Flu) Vaccine	☐ Hepatitis C Titer
☐ Quantiferon TB	☐ MMR Vaccine	☐ MMR Titer
☐ Respiratory Form Review	☐ Rabies Vaccine	☐ Rabies Titer
☐ Respiratory Fit Test (Qualitative)	☐ TD or TDaP Vaccine	☐ Varicella Titer
☐ Pulmonary Function Test/Spirometry	☐ Varicella Vaccine	
☐ TST/PPD (Tuberculosis skin test)	☐ Other Services Not Listed. (Please specify.): _____	

RESULTS (Please indicate where you would like exam and test results sent.) ☐ Encrypted Email or ☐ Secure Fax
Email Address: _____
Secure Fax#: _____(Fax machine is maintained in a manner that ensures privacy by restricting access to authorized personnel only.)
Contact Person: _____ Phone: _____

Additional information or comments: _____
Form Completed by: _____

Please email completed form to occhealth@olmmed.org.
Email is preferred, but you can also fax the completed form to 507.292.7001.