This form should be faxed, emailed or brought to the Clinic. Employee must have a photo ID at time of service.

## See Page 2 for locations information

| mployer                                      |   |                   |  |                   |  |                  |  |
|--|---|-------------------|--|-------------------|--|------------------|--|
| Company Name                                 | & Address:  |                   |  |                   |  |                  |  |
| Phone:                                       | Fax:  |                   | Contact Email:   |                   |  |                  |  |
| Bill this entity for Services:               |   | ☐ Company ☐       | Company   Work Comp Insurance  |                   | ☐ Other (list)   |                  |  |
| Authorizing Per                              | son:  |                   | Signature:   |                   |  |                  |  |
| nployee                                      |   |                   |  |                   |  |                  |  |
| Full Name:                                   |   | SSN:              | SSN: DOI   |                   | : Injury Date:   |                  |  |
| umicos to Duovido                            |   |                   |  |                   |  | (if applicabl    |  |
| ervices to Provide  If this is a workers con | npensation visit,                                     | please include wo | rker's compensation in   | surance name, pho | one number 8   | k billing addres |  |
|  | -   | •                 | •  | •                 |  | C                |  |
|  |   |                   |  |                   |  |                  |  |
| Workman's Con                                | npensation Injury                                     | : Diagnose        | & Treatment  |                   |  |                  |  |
| Pre-Placement Physical Exam:                 |   | Basic             | Basic With Muscloskeletal  |                   | Other Exams:   |                  |  |
| DOT Certification                            | on: Initial   | Re-certific       | ation  |                   |  |                  |  |
| Screenings:                                  | ☐ TB Scree  | n □ Electrocard   | diogram <b>Vision</b>  | _ `               | (Nursing Assessment and History or  ☐ Acuity ☐ Include Color (Ishiha |                  |  |
| <b>0</b>                                     | Audiogra  | n Pulmonary       |  |                   |  | •                |  |
| Respirator Use:                              |   | √Resnirator       | ☐ Respirator Questionnaire/Clearance   |                   | Hepatitis-B Immunity Titer   |                  |  |
| Blood/Urine Te                               | sting:  | ·                 | Questionnane, cicaran  | Respirato         | or Fit Testing   |                  |  |
| Immunizations:                               |   |                   | Influenza Hepatitis B  |                   | <br>Td   |                  |  |
| eath Alcohol Testing                         | ξ   |                   |  |                   |  |                  |  |
| Breath Alcohol                               | Testing (BAT):  | Non-E             | OOT [  | DOT               |  |                  |  |
| rugScreening                                 |   | Collection O      | nly (send to your M  | PO/Lah)           |  |                  |  |
|  | □Non Fodensl/I  |                   | , ,  | . ,               |  |                  |  |
| Agency:                                      | □Non-Federal (Non-DOT)  Tennessee Drug-Free Workplace |                   |  |                   |  |                  |  |
|  |   |                   | g authority/Agency:  |                   |  | -                |  |
| Reason:                                      | □ Pre-placement □ Random □ Return-to-Duty             |                   | ☐ Post-Acciden   | it 🗆 Reason       | ☐ Reasonable Cause   |                  |  |
|  |   |                   | □*Follow-up  |                   |  |                  |  |
| Sample Type:                                 | Urine (   | ollect Observed   | Blood  | Saliva            | Hair   |                  |  |
| Drug Screen Pan                              | els:  |                   |  |                   |  |                  |  |
| Urine Panels                                 | : □10 Panel   |                   | 9 Panel  | □12 Panel*        | □5 Panel   | □RAPID           |  |
|  | ☐ DOT Panel   |                   | 12 Panel*  | Bath Salts        | K2-Spice   |                  |  |
| Hair Panels:                                 | □5 Pan  | el                | 5 Panel+Opiates  | *Includes Subox   | one & Oxycodo  | ne               |  |
| Blood Panel: ☐9 Panel (                      |   | -1 / b \          | (only option) <b>Note</b> - additional costs apply for confirmation testing. |                   |  |                  |  |



Ballad Health Medical Associates

BHMA Occupational Medicine - Johnson City Located inside The Wellness Center 200 Med Tech Parkway, Suite 108 Johnson City, TN 37604

Ph: 423-915-5033 Fx: 423-952-3777

BHMA Occupational Medicine - Greeneville 438 E. Vann Rd, Suite 301 Greeneville, TN 37743

Ph: 423-636-9828 Fx: 423-638-2819

BHMA Occupational Medicine - Kingsport 111 West Stone Drive, Suite 120 Kingsport, TN 37660

Ph: 423-224-5126 Fx: 423-224-5140

BHMA Occupational Medicine - Abingdon 24530 Falcon Place Blvd, Suite 200 Abingdon, VA 24211

Ph: 276-628-1654 Fx: 276-619-9655

Bristol Regional Occupational Health 1230 Volunteer Parkway Bristol, TN 37620

Ph: 423-844-3360 Fx: 423-844-3369

Occumed Health Center 1490 Park Ave. NW Suite 5 Norton, VA 24273

Ph: 276-439-1440 Fx: 276-439-1441