Occupational Medicine Associates

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New Company Account Set Up for Drug & Alcohol Collection Only
Using your established lab and MRO

Company Name: _____

_____
Print Name & Title

Address_____City, State & Zip_____

Phone_____ Fax Number_____Do we need to call first? Y N

Email Address _____

Billing Address (if different from above) _____

Primary Contact_____ Secondary Contact_____

Phone_____ Phone_____

PLEASE PROVIDE A PHONE NUMBER THAT WE CAN REACH YOU MONDAY-FRIDAY 7:30AM TO 5:00PM PACIFIC STANDARD TIME. IF WE HAVE QUESTIONS OR PROBLEMS WITH THE COLLECTION WE NEED TO BE ABLE TO REACH SOMEONE.

WHAT LAB DO YOU USE: _____ WHO IS YOUR MRO NAME AND PHONE #: _____

WILL YOUR EMPLOYEES BE BRINGING IN THE CHAIN OF CUSTODY WITH THEM: _____

WE CAN STORE CHAIN OF CUSTODIES HERE IN OUR OFFICE. WILL YOU BE SENDING CCF'S TO US TO STORE: _____

WHAT TYPE OF TEST DO YOU REQUIRE: DOT _____ IF YES WHAT MODE FMCSA___ FAA___ FTA___ FRA___ USCG___ PHMSA___ NON-DOT TESTING_____ FOR NON-DOT WHAT TEST PANEL IF NOT PRE-PRINTED ON CCF _____ WILL YOU NEED BREATH ALCOHOL TESTING: YES___ NO___ DO YOU REQUIRE A BREATH ALCOHOL TEST FOR POST ACCIDENT _____ IF YOU ARE DOING DOT TESTING AND THE ACCIDENT DOESN'T MEET THE REQUIREMENT FOR A DOT TEST DO YOU WANT US TO DO A NON-DOT DRUG AND ALCOHOL TEST _____

VERY IMPORTANT PLEASE SEND A REFERRAL FORM TELLING US EXACTLY WHAT SERVICES YOU ARE REQUESTING WITH THE DONOR OR FAX ONE TO US AT 509-455-5555 OR EMAIL VALERIE@OMASPOKANE.ORG.