Occupational Services Intake Form

Complete this form and return it to registration with your picture ID and all paperwork you have with you regarding your services today. Thank you.

Full Name (First, Middle Initial, Last): _____

Home Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ /_____ /_____

Home/Cell Number: _____ Email: _____

Driver's License# _____ Exp Date: _____ (Mandatory for DOT Services)

Social Security Number: ___ ___ ___ /___ ___/___ ___ ___ ___ Sex At Time of Birth _____ Male _____ Female

Job Title / Position: _____

Employer/Company Name: _____

Supervisor's Name and Contact Number: _____

I authorize (Occupational Care Services Management) , and its associates to perform services and/or tests related to and authorized by me as an individual, employer, school, court or other authorizing agency. I authorize the release of any records, or other information to my employer, insurance carrier, or any other agent for whom these services are being authorized. I understand if services are found not authorized I will be responsible for payment of services related to this service. I give my consent and permission to (clinic name) to obtain a specimen to be analyzed for drug use, controlled substances, alcohol and/or misuse of prescription medication. I understand and I authorize the results of this testing to be disclosed to the employer requesting the services. Disclosure and use of results, information or any other private information will be limited in accordance with applicable laws covering confidentiality of records. I understand I have the right to refuse services and the employer authorizing and requesting such services can and will be notified. The signature below acknowledges this statement and if I am requested to provide a specimen for substance testing, I understand the specimen I am providing is my own. I understand that (clinic name) and its associates retain the right to refuse services to any individual not complying with State or Federal Laws and Regulation. I understand that (clinic name) is not responsible for employment outcomes based on drug or alcohol testing or any other screening test.

Signature: _____ **Today's Date:** _____