

AIRPORT MEDICAL CLINIC

OCCUPATIONAL MEDICINE REGISTRATION FORM

Have you been seen at the clinic since March 9, 2009? Yes___ No___

PLEASE PRINT CLEARLY

Social Security # _____ Employee ID # _____
(if known)

NAME:

First _____ MI _____ Last _____

Birth date ___/___/___ Gender: Male _____ Female _____

ADDRESS:

Street _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____

DRIVER'S LICENSE # _____ Class _____ State _____

Employer/Prospective Employer: _____

Job Class _____ Job Title _____

Department Unit _____

What are you here for?

- Drug Screen
- Breath Alcohol
- Pre-Employment Physical
- DOT Physical
- Respiratory Clearance
- Asbestos/Haz Mat
- Surveillance
- FAA
- Other _____

Drug Screen Type

- Non-Dot
- Dot

Reason for Drug Screen

- Pre-Employment
- Random
- Post Accident
- Return to Duty
- Follow-up
- Reasonable Suspicion
- Other _____

I have been offered a copy of NorthWorks Privacy Policy

Signature

Date