

ROBBINSDALE 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
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