



Employee Testing Request

*Today's Date:	
*Patient:	Birthday:

To be completed by Employee Supervisor/DER: (initials: _____)

*Company:	
Address:	
*Supervisor/HR contact:	
*Phone:	Fax:

Testing Requested			
	TB Skin Test (or by Chest X-Ray)		Flu Vaccine
	Non-DOT Urine Drug Screen - rapid test onsite, 11 panel test		DOT Urine Drug Screen
	Non-DOT Drug Screen – collect & send only		DOT Breath Alcohol
	Non-DOT Breath Alcohol		
*Reason for Test(s): Pre-Placement Random Post-Accident Reasonable Susp. <i>(for UDS/Breath Alcohol only)</i> Return to Duty Follow-up			

* Where do we send Test Results & Forms:
__ FAX (must be private/secure):

Other Instructions:

Plano Urgent Care - (469) 443-0275

www.PlanoUC.com

901 W. 15th Street, Plano TX 75075

Urgent Care Hours

Mon-Fri: 9am – 9pm

Saturday: 9am – 6pm

Sunday: noon – 6pm

