Post Accident Testing Request Form

Name of Company: _____

Contact person: _____

Address: _____

Phone number: _____

Name of injured employee: _____

Date of Birth: _____

Test requested: (check desired testing)

_____ Urine drug screen (using CVMC chain of custody, indicate DOT or Non-DOT)

_____ Breath Alcohol Test

Authorized by: _____ Date:_____