



400 W. Nolana #A1 • McAllen, TX 78504 • Phone: 956-928-1967 • Fax: 956-618-2490

COMPANY INFORMATION

Company Name: _____

Company Address: _____

Company Phone Number: _____ Company Fax Number: _____

REPORTING OF OCCUPATIONAL TESTING

Primary DER (Designated Employer Representative): _____

Primary DER Phone: _____ Primary DER Email: _____

Primary DER should Send Authorization Forms Have Access to Employee Medical Records Both

Secondary DER (Designated Employer Representative): _____

Secondary DER Phone: _____ Secondary DER Email: _____

Secondary DER should Send Authorization Forms Have Access to Employee Medical Records Both

Completed Results should be Faxed **or** Emailed **on a** Daily Weekly Monthly Basis

Notes on Reporting Issues: Designated Employer Representatives may have the same authority or different depending on which is marked above. Please make sure that Rio Plex Safety Council will only allow medical results to be given to the Designated Employer Representative(s) that are marked on this form

OCCUPATIONAL TESTING REQUIRED

Drug & Alcohol Collections

- DISA, Inc.
- Forward Edge
- ASAP Drug Solutions
- One Source Toxicology (Non Consortium)
- Breath Alcohol Test
- Instant Drug Screen (Rapid 5 Panel)
- Instant Drug Screen (Rapid 10 Panel)
- Hair Follicle Test

Occupational Health Services

- Respiratory FIT Testing (FIT)
- Pulmonary Function Testing (PFT)
- Audiometric Testing

Classroom OSHA Training

- Supplied Air Training
- Bottle Watch Training

Note: Each employee must have an "Authorization Form" filled out and sent to Rio Plex Safety Council prior to any testing being conducted. If you do not have a copy of this form please contact Tiffany Northrup at 956-928-1967

BILLING INFORMATION

Billing Address: _____

Attention To: _____ Contact Phone: _____ Contact Fax: _____

PO Required: YES NO

Note: Invoices will be sent out weekly and should be paid at Net 30 days.

Rio Plex Safety Council

400 West Nolana Suite A-1; McAllen Texas 78504

Main: 956-928-1967 Fax: 956-618-2490

Patient / Employer Information					
Patient Name		Date:		SSN:	
Employer Name		Office #		P.O. #	
Employer Address		DER:		Email:	
Services Required (please check all that apply)					
Drug & Alcohol Collections			Reason for Test		
<input type="checkbox"/>	Non-DOT Drug Screen	<input type="checkbox"/>	DISA, Inc - DCCHA	<input type="checkbox"/>	Pre-Employment
<input type="checkbox"/>	DOT Drug Screen	<input type="checkbox"/>	Account #	<input type="checkbox"/>	Pre-Access
<input type="checkbox"/>	Non-DOT Breath Alcohol	<input type="checkbox"/>	One Source Toxicology	<input type="checkbox"/>	Post Accident
<input type="checkbox"/>	DOT Breath Alcohol	<input type="checkbox"/>	DISA, Inc - DCCEO	<input type="checkbox"/>	Follow Up
<input type="checkbox"/>	Hair Follicle	<input type="checkbox"/>	Account #	<input type="checkbox"/>	Random
<input type="checkbox"/>	Rapid 10 Panel Drug	<input type="checkbox"/>	ASAP - NASAP	<input type="checkbox"/>	Return to Duty
<input type="checkbox"/>	Direct Observation	<input type="checkbox"/>	ASAP - LACC	<input type="checkbox"/>	Other:
<input type="checkbox"/>		<input type="checkbox"/>	Psychemedics / CRL	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	RPSC In House Screening	<input type="checkbox"/>	
DISA, Inc - DCCOF - Oral Fluids			with Hair Follicle/Randoms		
Functional and Physical Exams			Reason for Test/Comments		
<input type="checkbox"/>	Fit For Duty	<input type="checkbox"/>	Physicals		
<input type="checkbox"/>	Craft Personnel	<input type="checkbox"/>	Non-DOT		
<input type="checkbox"/>	Support Personnel	<input type="checkbox"/>	DOT		
Occupational Health Services			Classroom OSHA Training		
<input type="checkbox"/>	Audiometric Testing (Baseline & Annual)		Supplied Air Training		
<input type="checkbox"/>	Pulmonary Function Testing (MEQ Included)		1:30 PM		
<input type="checkbox"/>	Respiratory Fit Testing		Bottle Watch Training		
<input type="checkbox"/>	3M6000 Half Face		2:00 PM		
<input type="checkbox"/>	3M6000 Full Face		Respirator Training		
<input type="checkbox"/>	3M7800 Full Face		1:30 PM		
<input type="checkbox"/>	Scott AV 2000 Full Face		Pulmonary Clearance Verification		
<input type="checkbox"/>	Scott AV 3000 Full Face		The OSHA Respiratory Protection Standard (1910.134) states that a user of a respirator shall have the proper medical clearance to wear a respirator. If trainees are scheduled for a Pulmonary Function Test, they will complete the OSHA mandated questionnaire. Answers to the OSHA questionnaire and pulmonary function data will be submitted to the Occupational Testing Physician. The physician will submit a recommendation for respirator use based on the data provided for the individual. If trainees are not scheduled for a Pulmonary Function Test, it will be the responsibility of your company to provide medical clearance for the employees respirator use elsewhere. I have read the Pulmonary Clearance Statement, understand it, and acknowledge that my company is responsible for providing medical clearance for respirator use for our employees.		
<input type="checkbox"/>	Scott Xcel Half Face				
<input type="checkbox"/>	North 76008A Full Face				
<input type="checkbox"/>	North 7700 Half Face				
<input type="checkbox"/>	Drager Panorama - Nova				
<input type="checkbox"/>	MSA Ultra Elite Full Face				
<input type="checkbox"/>					
Comments:					
Please remind your employee(s) to arrive clean shaven if they are schedule for a FIT test.					
Authorization (Authorized By:)					
Print Name:			Date:		
Signature:			Time:		