775 Pole Line Road, Suite 101 Ph: 208-814-8100

SERVICES REQUEST FORM

Company Name: _____

Employee Name: _____ **(PICTURE ID REQUIRED)**

WORK INJURY MANAGEMENT:

Drug Screen required: Yes ☐ No ☐

Employer Contact Person/ Phone: _____

Work Comp. Carrier: _____

First Report of Injury completed: Yes ☐ No ☐

DRUG FREE WORKPLACE SCREENING:

☐ **DOT Drug Screen**

☐ **Non-DOT Drug Screen**

☐ **Breath Alcohol Test**

Please check reason for test: