Bayside
MEDICAL CENTER

Employer Protocol

Employer: _____ **Type of Business:** _____
Address: _____
Day Phone: _____ **Fax:** _____
Main Contact Information:
Name and Title: _____ **Phone:** _____
Email: _____ **Fax:** _____
Other Contact Information:
Name and Title: _____ **Phone:** _____
Email: _____ **Fax:** _____

Workers Comp. Carrier Name: _____ Phone: _____

All New Injuries:
Drug Screen: Yes____ No____ If Yes, DOT____ Non-DOT____ Breath Alcohol Test: Yes____ No____

Work Status: Call Employer: Yes____ No ____ Other: _____

Do you have Department of Transportation (DOT) employees? Yes____ No _____

I am Interested in the following services (Please check all that apply):

- ☐DOT/DMV Physicals
- ☐Annual Physical
- ☐Executive Physical
- ☐Respirator Physical
- ☐Fitness for Duty Exam
- ☐Pre-Placement Physical
- ☐Vision Exam
- ☐Grip Exam
- ☐Eudiometry Exam
- ☐ Proper Lifting and Back Injury Prevention Course
- ☐Urine Drug Screen
- ☐Random Drug Screen
- ☐Rapid Drug Screen
- ☐Breath Alcohol Test (BAT)
- ☐Ergonomic Assistance
- ☐On-Site Flu Clinic
- ☐First Aid and CPR Classes
- ☐Wellness Education

Other Instruction:

_____
_____
_____

Print Name _____ **Title:** _____

Signature: _____ **Date:** _____

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