BETHANY MEDICAL CENTER

"Your Health is our Concern"

Corporate Account Request for Service

___ **507 Lindsay St., H.P. – Ph# 336-883-0029 ext. 2214 Fax# 336-875-3412**
___ **1580 Skeet Club Rd., H.P. – Ph# 336-883-0029 ext. 1723 Fax# 336-875-3477**
_X_ **3402 Battleground Ave., GSO – Ph# 336-883-0029 ext. 6000 Fax# 336-545-4505**

Company Name New Hope Medical Training

Student

→ ~~Employee~~ Name _____ Date of Birth _____

Student

→ Employee Address _____ NCDL# _____

Appointment Date _____ Appointment Time _____

I authorize the employee/patient listed above to receive the following treatment:

____ Workers Comp Accident Treatment

____ Pre-Employment Physical: ____ Limited ____ Basic

____ Commercial Driver's License Exam (DOT Physical)

____ Pre-Employment **"Rapid"** Drug Screen: 5 Panel _____ 10 Panel ____

____ Regulated DOT Drug Screen: Pre-Employ____ Random/Suspicion____ Accident____ Oth___

Collection Only Drug Screen ____

____ Non- DOT Urine Drug Screen: Pre-Employ____ Random/Suspicion____ Accident____ Oth___

14 Panel _____ 14 Panel + Alcohol ____

____ Single Drug Confirmation Test

____ Breath Alcohol Test

____ HIV Testing

____ HEP B Shot HEP B Titers ____

_X_ TB Skin Testing - student will pay $ 25.00 at visit

____ Spirometry

____ Other _____

Please feel free to contact me if necessary:

Company Representative Name Hope Jacobs, RN, BSN

Contact Phone Number 336-617-9992 Contact Fax Number 336-464-2846

By my signature, I authorize Bethany Medical Center to treat the patient indicated above. I understand that all fees are the responsibility of the company listed above.

Hope Jacobs, RN / Director 10-1-18

Authorized Signature, Title Date