



# Chantilly Family Practice Center

Dr. Rajesh N. Mehra, Medical Director

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## CORPORATE REQUEST FORM

Company: \_\_\_\_\_ Authorizing agent: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Employee: \_\_\_\_\_ Job title: \_\_\_\_\_

## COMPANY REQUEST

DOT Physical	Audiogram
DOT Drug Screen	Breath Alcohol
Pre-Placement	Pulmonary Function
Random Testing	Urine Alcohol
Post-Accident	Vision Test
Non-DOT Drug Screen	X-Ray
STAT in house Non-DOT Drug Screen	Non-DOT Physical

## SPECIAL INSTRUCTIONS

\_\_\_\_\_  
\_\_\_\_\_

## EMPLOYEE INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

\_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Consent and Records Release Authorization

I, \_\_\_\_\_ consent to have the above listed procedures completed at Chantilly Family Practice Center by its physicians, nurses and/or technicians. I also authorize Chantilly Family Practice Center's agents to release all results, in writing, to \_\_\_\_\_.

I hereby release Chantilly Family Practice Center and any of its agents from any and all liability resulting from the disclosure of such information. I also agree to waive any physician/patient privileges that may otherwise exist.

\_\_\_\_\_ Employee Signature

\_\_\_\_\_ Witness Signature