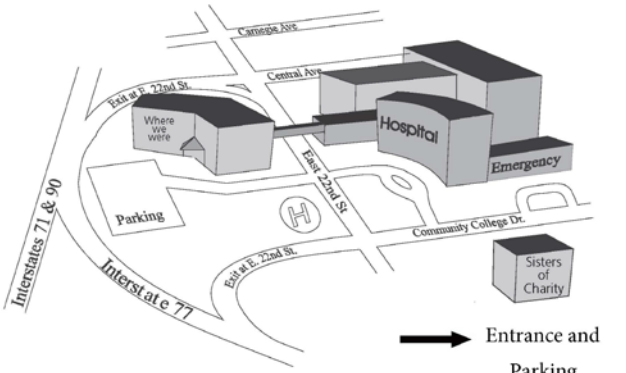




**ST. VINCENT CHARITY
MEDICAL CENTER**
OCCUPATIONAL HEALTH

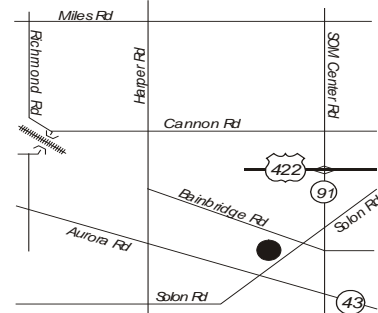
Downtown Cleveland
P: 216-363-2691 x 5
F: 216-2415814

Solon
P: 440-349-1796
F: 440-349-8154



Hours:
Monday-Friday
7:30 am - 6:00 pm

→ Entrance and
Parking
2475 E. 22nd Street
STE 310
Cleveland, OH 44115



Hours:
Monday – Friday
8:00 am – 8:00 pm

Solon Medical Campus
33001 Solon Road
Solon, OH 44139

**Use Urgent Care
Entrance on Right side
of building**

Employee/Candidate: _____

Company: _____

Test/Exam must be completed by (date): _____

Person Authorizing Test: _____ Phone: _____

**Life or Limb Threatening
Injuries
Go directly to the
Emergency Department**

<input type="checkbox"/> Injury Care/Exposure <input type="checkbox"/> Post injury drug screen <input type="checkbox"/> Post injury BAT Please indicate if testing is: <input type="checkbox"/> Federal/DOT <input type="checkbox"/> Non Federal	<input type="checkbox"/> Exam <input type="checkbox"/> New Hire <input type="checkbox"/> Existing Employee If applicable indicate type of exam: <input type="checkbox"/> DOT <input type="checkbox"/> OSHA Surveillance <input type="checkbox"/> Wear a Respirator <input type="checkbox"/> Return to Work <input type="checkbox"/> T-8 Bus or Van Driver	<input type="checkbox"/> Substance Testing <input type="checkbox"/> Urine drug screen <input type="checkbox"/> 5-Panel <input type="checkbox"/> 10-Panel <input type="checkbox"/> 9-Panel <input type="checkbox"/> Nicotine <input type="checkbox"/> Hair Testing <input type="checkbox"/> Saliva <input type="checkbox"/> Breath Alcohol Test Please indicate if testing is: <input type="checkbox"/> Federal/DOT <input type="checkbox"/> Non Federal <input type="checkbox"/> Instant Kit Reason for Test: <input type="checkbox"/> Pre Placement <input type="checkbox"/> Random <input type="checkbox"/> Accident/Injury <input type="checkbox"/> Cause/Suspicion <input type="checkbox"/> Return to Work <input type="checkbox"/> Follow up EAP
<input type="checkbox"/> Misc <input type="checkbox"/> TB Test 1 or 2 <input type="checkbox"/> T-Spot <input type="checkbox"/> Hepatitis <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Other: _____		
Special Instructions:		