Dear Prospective Students and Employees:

The completion of a current TB Skin Test, or Screening, within one year, is required for admission to Triad Medical Academy. If you are in need of a current test, please print the form below, and take to Bethany Medical Center, 3402 Battleground Avenue, Greensboro, NC.

No appointment is necessary. A cost of $20.00 will be paid by the prospective student or employee, at the time of the visit.

If you have any questions, please contact us a info@triadmedicalacademy.com

*The form below is **ONLY** to be used by Triad Medical Academy prospective students and/or employees.

Kind regards,

Tracy Goodman
Director
Triad Medical Academy, LLC
www.triadmedicalacademy.com
336.510.2582

BETHANY MEDICAL CENTER

"Your Health is our Concern"

*EMPLOYEE OR STUDENT TO PAY $20 AT TIME OF VISIT

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 GRISWOLD HOME CARE (TRIAD MEDICAL ACADEMY)

Employee Name ____________________ Date of Birth __________

Employee Address ____________________ NCDL# __________

Appointment Date WALK-IN 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 ONLY
____ Spirometry
____ Other ____________________

Please feel free to contact me if necessary:

Company Representative Name TRACY GOODMAN, DIRECTOR

Contact Phone Number 336.510.2582 Contact Fax Number 336.281.5395

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.

Tracy Goodman, Director 06/18/2024

Authorized Signature, Title Date