OCCUPATIONAL HEALTH SERVICES CLIENT INFORMATION FORM

COMPANY NAME:		
CONTACT PERSON:	PHONE:	EMAIL:
ALTERNATE CONTACT PERSON:	PHONE:	EMAIL:
SECURE FAX:	PERFERRED METHOD OF RECEVING REPORTS (Please fill in one option) ☐ Email: ☐ Fax: ☐ Telephone :	
Mailing Address:		

BILLING INFORMATION

COMPANY BILLING ADDRESS (IF DIFFERENT THAN MAILING ADDRESS):

WORKERS COMPENSATION INSURANCE INFORMATION

WC INSURANCE CARRIRER:	
WC INSURANCE BILLING ADDRESS:	
WC CONTACT PERSON & PHONE:	Would you like your WC Invoices billed to: ☐ Your company ☐ Directly to your carrier

SERVICES NEEDED

☐ INJURY CARE ☐ TB TESTING ☐ PRE-PLACEMENT PHYSICALS ☐ DOT PHYSICALS	☐ PRE-PLACEMENT PHYSICAL TO INCLUDE: ☐ PHYSICAL EXAM ☐ URINALYSIS ☐ DRUG TESTING (INDICATE TYPE) ☐ PULMONARY FUNCTION TESTING ☐ VACCINATIONS (Hep B) ☐ BAT (Breath Alcohol Testing)

DRUG SCREENING INFORMATION (IF APPLICABLE)

SERVICES NEEDED (CHECK ALL THAT APPLY) ☐ DOT PANEL (Drug screening) ☐ Non-DOT Instant Urine (Point of Care Testing): ☐ 5-Panel (Rapid Drug Screening) ☐ 10-Panel (Rapid Drug Screening) DO YOU HAVE A THIRD PARTY ADMINISTRAOR FOR YOUR COMPANY'S DRUG SCREENING PROGRAM? ☐ YES ☐ NO	IF YES, PLEASE INCLUDE THE NAME OF YOUR 3RD PARY ADMINISTRATOR:

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PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

1. How many employees does your company currently have? ____
2. Average new employees hired each year? ____
3. How many drug/alcohol tests does your company average per year? ____
4. What is your average number of injuries per year? _____
5. How many DOT/Pre-Employment physicals do you perform in a year? ____

OCCUPATIONAL INJURY

Please check all testing you would like performed in the event of an occupational injury.

- DOT Drug Screen
- 5-Panel Rapid Drug Screen
- 10-Panel Rapid Drug Screen
- Breath Alcohol Testing (BAT)
- TB Test
- Pulmonary Function Test (PFT)
- None

REPORTING (CHECK ALL THAT APPLY)

How would you like to receive employee results?

- Fax
  Please provide secure fax line: ______________________________________
- Mail
  Please provide address:____

PLEASE WRITE BELOW ANY ADDITIONAL INFORMATION WE MAY NEED

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NEW HIRE/PRE-EMPLOYMENT

Please check all testing you would like performed during new hire/pre-employment.

- DOT Drug Screen
- 5-Panel Rapid Drug Screen
- 10-Panel Rapid Drug Screen
- Breath Alcohol Testing (BAT)
- TB Test
- Pulmonary Function Test (PFT)
- None

REPORTING (PLEASE CHECK ALL THAT APPLY)

How would you like to receive employee results?

- Fax
  Please provide secure fax line: ____
- Mail
  Please provide address:____

PLEASE WRITE BELOW ANY ADDITIONAL INFORMATION WE MAY NEED

When completed please email to koady@lansingurgentcare.com or Fax to 517-333-9201