



OCCUPATIONAL MEDICINE SERVICES EMPLOYER PROTOCOL

To use our Occupational Medicine Services please complete, sign and submit this form for initial account set-up. This information is required only once and will not need to be submitted with each Employee sent in.

Please check below which services are needed:

- Worker's Compensation
- Pre-Employment Physical/Testing
- Drug Screening/Collection
- DOT Medical Exam

Date: _____

Company Name: _____ Contact: _____

Company Address: _____ Telephone #: _____

Fax #: _____ Email: _____

Authorizing Personnel: _____ Telephone #: _____

After Hours Contact: _____ After Hours Telephone #: _____

Worker's Compensation Insurance Carrier: _____

Claims Address: _____

Telephone #: _____ Fax #: _____

Does your company require a:

Company Medical Transcript: Yes No Work Status Note: Yes No
How would you prefer to receive this information?

Fax #: _____ **OR** Email: _____ Attention to: _____

Drug Screen on all new cases? Yes No

Ten-Panel Rapid Yes No **OR** Ten-Panel w/ MRO review Yes No
Samples requiring further testing will automatically be sent out to lab for MRO confirmation.

Will the company pay for the Drug Screen? Yes No

Will the injured worker be accompanied by a Supervisor? Yes No

Will the injured worker have a Hard Copy Authorization to evaluate and treat? Yes No

If not, who do we contact for a Hard Copy Authorization? _____

Is an Authorization required for Follow-up Visits? Yes No

Does the company have modified/light duty in place? Yes No
(Employee can be assigned modified/light duty instead of days off, if applicable)

Is an Authorization required for Referrals to Specialist or Special Testing? Yes No

Will the company be making appointments for Referrals? Yes No

Does the company have a designated Pharmacy? Yes No

If so, which Pharmacy: _____

We are here to provide a service for your company, so please let us know if there are any special instructions we may assist you with.

Authorized Signature - Print & Sign, Title

Date