

COMPANY PROFILE

Name of Company

Street Address

City State Zip

Phone Fax

Contact Person Title

Secondary Contact Title

of employees _____
Hours of Operation _____
Type of business _____
SIC Category:
____ Manufacturing _____ Transportation
____ Construction _____ Service
____ Wholesale _____ Fin/Ins/Real Est
____ Public Administration _____ Misc. _____
Are toxic/hazardous chemicals present? Yes No
Specify (or supply MSD sheet) _____

POST INJURY INSTRUCTIONS

Type of work available (Please check (✓) appropriate boxes)

- Modified Duty No Modified Duty Call for Instructions

DRUG TESTING REQUIREMENTS

Type of Test

- Urine Drug Screen
- Breath Alcohol
- Other _____
(Specify)
- Collection Only

Purpose for Test

- Random
- Post – Accident
- Periodic
- Reasonable Cause
- Other _____

*Designated Lab for D/S

Address: _____
Phone #: _____
Confidential Contact:
Name: _____
Policies on File?
 Yes No

PHYSICAL EXAMINATIONS / HEALTH SCREENINGS

Are physical exams required? Yes No (If Yes, please check (✓) appropriate boxes)

- Employment Annual Bloodborne Pathogen Exposure
- DOT Executive Health Surveillance _____
(Specify Type)
- Return to Work Termination
- Other _____ See supplemental sheets for special instructions

BILLING AND REPORTING INSTRUCTIONS

Hospital is to maintain company health records

Billing contact: _____ Phone: _____

Special Instructions: _____

INSURANCE INFORMATION

Worker's Comp Carrier: _____ Group Carrier: _____

Street Address: _____ Street Address: _____

City, State, Zip: _____ City, State, Zip: _____

Telephone: (____) _____ Telephone: (____) _____

(Signature of Company Official)

(Date)

(Signature of Company Official)

(Date)