COMPANY SET UP

Company Name _____ Date _____

Address _____ City _____Zip _____

Email _____ Phone_____**# of Employees** _____

1st Contact _____	2nd Contact _____
Email _____	Email _____
Phone _____	Phone _____

Billing: Address _____ City _____Zip _____

WORKERS COMP INFO

Name Ins_____

Address _____City _____ Zip _____

Policy# _____

Workers Compensation – post-injury testing

Drug Testing instructions for WC ONLY:_____

BAT instructions for WC ONLY:_____

List of Non-Injury Needed:

PHYSICAL EXAMINATIONS

☐ Pre-Placement Exam ☐ Respiratory Exam ☐ Return to Work Exam ☐ Fit for Duty Exam ☐ Asbestos

☐ DOT Recertification ☐ DOT Exam ☐ Firefighter ☐ MCOLES ☐Hazmat ☐ Other: _____

DRUG AND ALCOHOL SCREENING

☐ 5 Panel ☐ 10 Panel ☐ 9 Panel ☐ Breath alcohol ☐ Instant ☐ Lab based ☐ Non-DOT ☐ DOT

☐ Other:_____

REASON FOR SCREENING

☐ Pre-Placement ☐ Random ☐ Follow-Up ☐ Reasonable Suspicion ☐ Other: _____

VACCINATIONS, LAB SERVICES, OTHER TEST

☐ PPD/TB ☐ Fit Test ☐ TDAP ☐ MMR ☐ Audio ☐ PFT ☐ Hep B Series ☐ Titers ☐ Other_____

*****Please email the completed form to : Billing@occmedconnect.com or fax to: 734-333-8005.**