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**COMPANY PROFILE**

CSR: \_\_\_\_\_

Date: \_\_\_\_\_

Company Name: \_\_\_\_\_ Corporate Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Number of employees: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

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Primary Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Additional company contacts**

1. \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

2. \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

3. \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

4. \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

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**BILLING INFORMATION:**

Company or Corporate Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Contact: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please send billing correspondence via: Mail **OR** Fax **OR** Email

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**INSURANCE:** Work Comp Insurance Carrier: \_\_\_\_\_

Policy No: \_\_\_\_\_ Phone: \_\_\_\_\_

Please send all Work Comp Invoices to: Insurance **OR** Company

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**POST OFFER SERVICES**

**Pick One:** ( ) Patient Pays ( ) Bill Company

**Main Contact:** \_\_\_\_\_

( ) Drug Screen (**PICK ONE**):

<b>Rapid</b> Drug Screens __ Urine 5 panel      __ Urine 10 panel __ Urine 8 panel      __ Saliva 5 panel
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OR

<b>Laboratory</b> Drug Screens __ Urine 5 panel      __ Hair Test 5 panel __ Urine 8 panel      __ Collection Only DS ( <i>please provide chain of custody form</i> ) __ Urine 10 panel __ Saliva 5 panel
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\*\*Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

__ Breath Alcohol Test (BAT)
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OR

__ Oral Alcohol Screening
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\*\*Alcohol Results: Same as Drug Screen

( ) Physical (**PICK ONE**):

__ Basic Physical Exam <i>(please provide job description)</i>
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OR

__ DOT Physical <i>(Chauffeur license)</i>
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\*\*Physical: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Audiogram: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Other: \_\_\_\_\_

**DOT POST OFFER:** (*Must be a CDL driver, not Chauffeur*)

**Pick One:** ( ) Patient Pays ( ) Bill Company

**Main Contact:** \_\_\_\_\_

( ) Drug Screen (**PICK ONE**):

__ DOT Drug Screen
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OR

__ Collect Only DOT Drug Screen ( <i>please provide chain of custody form</i> )
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\*\*Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

__ DOT Breath Alcohol Test (BAT)
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OR

__ DOT Oral Alcohol Screening
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\*\*Alcohol Results: Same as Drug Screen

( ) DOT Physical: **Pick One:** ( ) Patient Pays OR ( ) Bill Company

\*\*Physical: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

**POST ACCIDENT TESTING (NON INJURY):**

**Main Contact:** \_\_\_\_\_

( ) Drug Screen (**PICK ONE**):

<b>Rapid</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Urine 10 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Saliva 5 panel

OR

<b>Laboratory</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Hair Test 5 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Collection Only DS ( <i>please provide chain of custody form</i> )
<input type="checkbox"/> Urine 10 panel	
<input type="checkbox"/> Saliva 5 panel	

\*\* Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

<input type="checkbox"/> Breath Alcohol Test (BAT)
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OR

<input type="checkbox"/> Oral Alcohol Screening
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\*\*Alcohol Results: Same as Drug Screen

\*\*If accident meets DOT criteria, DOT drug screen and DOT BAT will be completed\*\*

**WORKERS COMPENSATION INJURY:**

**Main Contact:** \_\_\_\_\_

( ) Treat injury

( ) Drug Screen (**PICK ONE**):

Do Drug Screen ONLY IF REQUESTED

<b>Rapid</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Urine 10 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Saliva 5 panel

OR

<b>Laboratory</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Hair Test 5 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Collection Only DS ( <i>please provide chain of custody form</i> )
<input type="checkbox"/> Urine 10 panel	
<input type="checkbox"/> Saliva 5 panel	

\*\*Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

Request Only

<input type="checkbox"/> Breath Alcohol Test (BAT)
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OR

<input type="checkbox"/> Oral Alcohol Screening
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\*\*Alcohol results: Same as Drug Screen

Work status report: ( ) Give to patient **OR** ( ) Email to: \_\_\_\_\_

**RANDOM TESTING NON-DOT:**

**Main Contact:** \_\_\_\_\_

( ) Drug Screen (**PICK ONE**):

<b>Rapid</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Urine 10 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Saliva 5 panel

OR

<b>Laboratory</b> Drug Screens	
<input type="checkbox"/> Urine 5 panel	<input type="checkbox"/> Hair Test 5 panel
<input type="checkbox"/> Urine 8 panel	<input type="checkbox"/> Collection Only DS ( <i>please provide chain of custody form</i> )
<input type="checkbox"/> Urine 10 panel	
<input type="checkbox"/> Saliva 5 panel	

\*\*Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

<input type="checkbox"/> Breath Alcohol Test (BAT)
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OR

<input type="checkbox"/> Oral Alcohol Screening
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\*\*Alcohol Results: Same as Drug Screen

( ) Random Consortium - COM will facilitate your random selections (Tara Parrish, Drug Screen Coordinator, will contact you)

**RANDOM TESTING DOT:**

**Main Contact:** \_\_\_\_\_

( ) Drug Screen (**PICK ONE**):

DOT Drug Screen      OR       Collect Only DOT Drug Screen (*please provide chain of custody form*)

\*\*Drug Screen Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

( ) Alcohol (**PICK ONE**):

DOT Breath Alcohol Test (BAT)      OR       DOT Oral Alcohol Screening

\*\*Alcohol Results: Same as Drug Screen

( ) Random Consortium - COM will facilitate your random selections (Our Drug Screen Coordinator will contact you)

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**RESPIRATOR APPROVALS:**

Required by OSHA:

- ( ) Respirator Questionnaire
- ( ) Respirator Fit Testing (*please provide mask before fitting*)

Others:

- ( ) Pulmonary Function Test (PFT or Spirometry)      ( ) Annual      ( ) Baseline      ( ) Provider request
- ( ) Physical Exam      ( ) Annual      ( ) Baseline      ( ) Provider request
- ( ) Chest X-ray

\*\*Respirator Results: ( ) Fax to: \_\_\_\_\_ OR ( ) Email to: \_\_\_\_\_

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**ADDITIONAL SERVICES:**

- ( ) Hepatitis B Series and/or Titer
  - ( ) TB Screening
  - ( ) On-Site Services (many of our services including drug screens, respirators, etc can be done on-site) – Our Onsite Coordinator will contact you with more information
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