Faith Immediate Care & OCCUPATIONAL MEDICINE

COMPANY Information

Company Name _____
Contact Name _____
Tel# _____ Fax# _____
Email Address _____ @ _____
Do you prefer your invoices/bills ___☐ Faxed ___☐ Emailed ___☐ Mailed?

Company Physical Address
Street _____ Suite#/Floor _____
City _____ State _____ ZIP _____

Company Billing Address ___☐ ***SAME AS PHYSICAL ADDRESS***
Attention to _____
Street _____ Suite#/Floor _____
City _____ State _____ ZIP _____
Email Address _____ @ _____
Tel# _____ Fax# _____

Workers Compensation Insurance
Insurance Name _____
Policy # _____
Claim# (if any) _____
Agent/Adjuster Name _____
Address _____
Tel# _____ Fax# _____

SERVICES NEEDED

WORKERS COMPENSATION _____ **Yes**

DRUG SCREENS
_____ DOT
_____ Non-DOT
_____ Pre-employment
_____ Rapid Panel 5, 5+, 10, 10+
_____ Random
_____ Reasonable Suspicion
_____ Post Accident
_____ Urine Collect
_____ Hair Collect
_____ Oral Collect

BAT (Breath Alcohol Test)
_____ DOT
_____ Non-DOT
_____ Pre-employment
_____ Rapid
_____ Random
_____ Post-accident
_____ Reasonable Suspicion

PHYSICALS
_____ DOT (New, Recertification, Extension)
_____ Non-DOT (Pre-employment, Annual)
_____ Return to Work (RTW)
_____ Follow Up Physical
_____ Other _____
_____ Ability Test (Job Specific)

Respirator
_____ Pulmonary Function Test (PFT)
_____ PFTClearance
_____ OSHA Questionnaire
_____ Respirator Fit / Mask Fit Qualitative

Other
_____ Audiogram
_____ TB Testing _____ Titers
_____ Wellness Exam _____ MMR
_____ Immunizations _____ Hep B
_____ Other as needed _____ Hep A
_____
_____