Account Registration/Update

Company Name: _____

Address: _____

Federal Tax ID#: _____ Number of employees: _____ # of shifts: _____

Main Contact Name: _____ Phone: _____

E-Mail: _____ Fax: _____

****Please attach a list of any other Contacts, and Company representatives authorized to receive information****

TEST PROCEDURES REQUIRED ON PRE-PLACEMENT EXAMS:

Drug screen: Yes ( ) No ( ) Observed Drug screen? Yes ( ) No ( ) Saliva Alcohol: Yes ( ) No ( ) Breath Alcohol: Yes ( ) No ( )
DOT Physicals: Yes ( ) No ( ) Industrial Physicals: Yes ( ) No ( ) Audiogram: Yes ( ) No ( ) Respirator Approval: Yes ( ) No ( )

REQUIREMENTS AND INFORMATION ON A WORK-RELATED INJURY:

*****Please attach information and cover page of Workers Compensation insurance*****

Drug screen: Yes ( ) No ( ) Observed Drug screen? Yes ( ) No ( ) Saliva Alcohol: Yes ( ) No ( ) Breath Alcohol: Yes ( ) No ( )

How would you prefer test results reported? [ ] Phone [ ] Fax [ ] Email

Phone: _____ Fax: _____ E-mail: _____

Please add any comments, additional information, other test not listed or any special instructions:

_____

_____

Special Instructions: Please send employee with an authorization /referral form with the exception of being accompanied by an approved supervisor.

All Physical and Injury Reports will be sent CONFIDENTIAL when completed to:

Contact Name: _____

Signature: _____ *Date:* _____

Please return complete form to:
Email: drugscreen@windsorworkcare.com, josuedelarosa@corporatecareclinic.com
Phone: (574) 266-6555 Fax: (574) 266-6888

Authorization/Referral Form

3100 Windsor Ct. Elkhart, IN 4651
Ph: 574-266-6555 Fax: 574-266-6888

420 N. Main St. Middlebury, IN 46540
Ph: 574-285-3400 Fax: 574-825-3424

Patient's Name_____ Date _____

Birth Date: _____ SS #_____

Company Name: _____

Authorized by:
Print _____ Signature _____

TREATMENT REQUEST

[ ] Patient Pay [ ] Company Pay

[ ] DOT Physical [ ] Industrial Physical Pre-Placement [ ] PFT
[ ] Respirator Approval [ ] Respirator Fit Test [ ] Audiogram
[ ] W/C Initial [ ] W/C Follow Up [ ] TB/Mantoux
[ ] Hep B Vaccine [ ] Tetanus [ ] COVID-19 Rapid Swab
[ ] Other_____

DRUG AND ALCOHOL TEST

[ ] OBSERVE [ ] DO NOT OBSERVE

[ ] DOT Drug Test [ ] Saliva Alcohol Test [ ] Breath Alcohol Test

[ ] Urine Collection only [ ] Hair Test [ ] Oral Drug Screen

[ ] Rapid Drug Screen (choose panel below)

[ ] 4 Panel [ ] 5 panel [ ] 6-10 panel

REASON FOR TEST

[ ] Pre-Placement [ ] Post-Accident [ ] Reasonable Cause [ ] Random

***Picture ID Required for All Drug Tests and Work Injury Visit ***