CORPORATE CARE
OCCUPATIONAL MEDICINE

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: marion@corporatecareclinic.com or mark@corporatecareclinic.com Phone/Fax (574) 266-6888