

CLIENT/ACCOUNT SET-UP FORM

DATE: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT: _____

PHONE #: _____ FAX#: _____

COMPANY E-MAIL ADDRESS: _____ # of Employees: _____

WORKMENS' COMPENSATION INFORMATION

W/C CARRIER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ADJUSTER'S NAME: _____

PHONE #: _____ FAX #: _____

BILLING INFORMATION

INVOICE ALL WORK INJURY TO:

_____ WORK COMP INSURANCE _____ COMPANY

INVOICE ALL PHYSICALS/DRUG SCREENS/ OTHER SCREENING SERVICES TO:

_____ COMPANY AT THE ADDRESS INDICATED ABOVE

_____ COMPANY - @ A DIFFERENT ADDRESS

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TYPE OF SERVICES REQUESTING

_____ **TREATMENT OF WORK INJURIES**

_____ W/DRUG SCREEN – TEST PANEL _____

_____ W/O DRUG SCREEN

_____ W/ALCOHOL (_____ BREATH, _____ BLOOD, _____ URINE)

_____ W/O ALCOHOL

_____ **PHYSICAL EXAMS**

_____ DOT _____ RESPIRATORY CLEARANCE _____ PRE-EMPLOYMENT _____ OTHER

For Pre-Placement Exams Select Test Components

_____ EXAM _____ DRUG SCREEN _____ VISION _____ AUDIO

_____ PFT

_____ LABS (SPECIFY) _____

_____ IMMUNIZATIONS (SPECIFY) _____

_____ **SUBSTANCE ABUSE TESTING**

_____ COLLECTION ONLY _____ CHAIN OF CUSTODY TO BE PROVIDED BY COMPANY

_____ NON-REGULATED (Test Panel _____) _____ HW CHAIN OF CUSTODY FORM

_____ DOT

_____ ALCOHOL (_____ BREATH, _____ BLOOD, _____ URINE)

OTHER: _____
