

WorkFit Occupational Health **EMPLOYER PROFILE / SERVICE INFORMATION**

(Please fill out and fax to 402 / 934-5939)

DATE: _____

COMPANY: _____ PHONE: _____

ADDRESS: _____ FAX: _____

_____ EMPLOYEE #: _____

CONTACT: _____ PHONE: _____ EMAIL: _____

BILLING ADDRESS (if different than above) _____

WORK COMP CARRIER: _____ PHONE: _____

ADDRESS _____

DRUG SCREENS Type: NON _____ DOT _____ Instant Test _____ Panel: _____

Results Method: Fax _____ Phone (voice mail) _____ Web _____

Mail: Yes _____ No _____ if yes, Address: _____

BREATH ALCOHOL Yes _____ No _____

Reason for test: all _____ pre-employment _____ random _____ post accident _____ reasonable suspicion/for cause _____

Results Method: Fax _____ Phone (voice mail) _____

Mail: Yes _____ No _____ If yes, Address _____

PHYSICALS

NON-DOT Provider _____ Nurse _____

Results Method: Phone (voice mail) _____ Fax _____ Fax # _____

Mail: Yes: _____ No: _____ If yes, Address _____

DOT Card Give to employee: Yes _____ No _____

Which Card: Motor Carrier _____ Both _____ Neither _____

Medical Form Give to employee: Yes _____ No _____

Results Method: Phone (voice Mail) _____ Fax _____ neither _____ #: _____

Mail: Yes _____ No _____ Address: _____

BACK SCREENS Yes _____ No _____

INJURY CARE Can we dispense meds from our in hours Pharmacy? Yes _____ No _____
Does your company have a prescription plan that employee's use? Yes _____ No _____