Date:

Company Information Form

Company Name			No. of Employees
Company Address	City	State	Zip
Company Phone	Company Fax		
Contact Name	Contact Email		

Personnel Able to Authorize Visits	Phone
1.	
2.	
3.	
4.	
After-hours Contact	**Phone**
1.	
2.	

Accounts Payable Contact

Name

Phone

Email

Fax

Workers Compensation Insurance Carrier Information

Carrier Name		Carrier Phone	
Carrier Address	City	State	Zip
Policy #	Effective Date (if available)	Carrier Fax	
Special Instructions			

Reason for Visit

○ On the Job Injury ○ Pre-Employment Services

○ Other: ____________________

Drug Screen with Injury? ○ Yes ○ No

Standard Drug Screens

○ Standard 10-Panel

○ Standard 5-Panel

○ DOT Drug Screen

Instant Drug Screens

○ Instant 10-Panel

○ Instant 5-Panel

Other Services

○ Breath Alcohol Test

○ DOT Physical

○ Basic Occupational Physical

○ Other (please explain): ____________________

Collection Only Lab Name: ____________________

Results Reporting

Please specify your preference for ***drug screen results only***

○ **Online** Name ____________________

Email ____________________

○ **Fax** Contact Name ____________________

Number ____________________

Please specify your preference for receiving physicals, work, status reports, etc.

○ **Mail** ____________________

○ **Fax** ____________________

○ **Email** ____________________

Thank you for choosing CareNow as your occupational healthcare provider.
Please fax completed form to **844-226-1336**, ATTN: OccMed Team **or** email to **CareNowOccMed@HCAHealthcare.com**