COMMUNITY HEALTHCARE SYSTEM®
Occupational Health

COMPANY PROFILE

COMPANY INFORMATION

Name: _____ Store # (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____-_____-_____ Fax: _____-_____-_____ Business Type: _____ #Employees _____

BILLING INFO

Address (if different from above): _____ City: _____ State: ____ Zip: _____
Billing Contact: _____ Phone: _____-_____-_____

WHERE TO SEND RESULTS

Preferred Method of Communication: ☐ **Encrypted Email** ☐ **Online Portal** ☐ **Fax** _____-_____-_____

Name: _____ Phone: _____-_____-_____ Email: _____

Title: _____
☐ Substance Abuse Tests ☐ Physicals ☐ Workers' Comp ☐ After Hours (Cell#: _____-_____-_____)

Name: _____ Phone: _____-_____-_____ Email: _____

Title: _____
☐ Substance Abuse Tests ☐ Physicals ☐ Workers' Comp ☐ After Hours (Cell#: _____-_____-_____)

Do you use a Third Party Administrator (TPA) for your Drug Screens and/or Physicals? ☐ Yes ☐ No

Name of TPA: _____

WORKERS' COMP INFO

WC Insurance Provider: _____ Light Duty Available? ☐ Yes ☐ No
Bill to: ☐ WC Insurance ☐ Company

Post-Accident Drug Testing: ☐ Required ☐ Optional ☐ No Testing
Post-Accident Alcohol Testing: ☐ Required ☐ Optional ☐ No Testing

SUBSTANCE ABUSE TESTING

☐ DOT ☐ Hair Test ☐ Breath Alcohol ☐ Collection Only on Your Company Chain of Custody Form
(Please send copy of CCF along with profile)

☐ Non-DOT (☐ 5-Panel ☐ 10-Panel)
Would you like instant result test? (Non-DOT only): ☐ Yes ☐ No

PHYSICAL EXAMS & SURVEILLANCE

Physicals: ☐ Non-DOT ☐ DOT ☐ Essential Demands Screening (Ergonomics/Lift Test)

Add'l Testing: ☐ Audiogram ☐ Pulmonary Function ☐ Respirator Fit Test ☐ Chest X-Ray ☐ EKG ☐ TB Test
☐ Bloodwork: _____
☐ Vaccines/Immunizations: _____

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