**❑ New Company ❑ Company Update For Contact information only – Not a Contract**

|  |
| --- |
| **COMPANY NAME**: |
| Address: |
| City: State: Zip:  |
| Phone: Fax: (Secure Fax: Yes No) |

|  |
| --- |
| **AUTHORIZED POINT OF CONTACTS** *The following* *will be able to schedule appointments and receive results if requested* |
| 1. Name:  Receive Results (All? Drug Screen? Exams?)  Can Schedule |
|  Phone: Cell: E-mail: |
| 2. Name:  Receive Results (All? Drug Screen? Exams?)  Can Schedule  |
|  Phone: Cell: E-mail: |
| 3. Name:  Receive Results (All? Drug Screen? Exams?)  Can Schedule |
|  Phone: Cell: E-mail: |

|  |
| --- |
| **BILLING** *Check one* **E-mail Fax USPS** |
| Company:  |
| Accounts Payable Contact: Phone: |
| E-mail: |
| Fax:  |
| Address: City: State: Zip Code:  |

|  |
| --- |
| **WORKERS COMP CARRIER: Policy #:** |
| Address: |
| City: State: Zip Code: |
| Phone: Fax:  |
| **Company W/C Contact**: **\*We will need claim number ASAP** |
| Phone: Email:  |
| OHS sends WC bills directly to WC insurance carrier indicated above unless marked below |
| Work related injury bills send to: Employer **\*** *ALL THE WC BILLING PER THE TENNESSEE FEE SCHEDULE* |

**OCCUPATIONAL SERVICES**

**DRUG SCREENS**

 NO Drug Screening Pre-Employment  Random  Post Accident  Reasonable Suspicion  Follow - Up

  Collection only ( \_\_\_\_You send in a supply of chains) ( \_\_\_\_Employee will bring chain)

 OHS lab & MRO  TN Certified Drug Free Work Place NonDOT DS (Specify Panel\_\_\_\_\_\_)  Instant 11panel DS  DOT Drug Screens

**PHYSICALS**

 NonDot physicals DOT physicals Respiratory physicals Hazmat physicals Silica Exams Other

lkl Company will provide own physical forms Use OHS physical forms

**MISCELLANEOUS**

 Audiogram Spirometry Mask Fit Test (specify type below) Breath Alcohol Screening EKG X-rays (specify x-rays below)

 TB Skin Test Hepatitis B injection Hepatitis B Titer Flu Vaccine Blood Labs (\_\_\_\_Co Provides Kit)(­­­­\_\_\_\_ OHS Lab (specify labs below)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not listed above, please indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete, sign and return, authorizing OHS to perform the services checked above