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

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

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| **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: |

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

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| **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