
Company Profile



Please enter information where you see the gray shading. After you are finished, save the form and email it as an attachment to patty.stovall@hcahealthcare or fax it to (940) 384-4726.

Company Information

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

HR Contact: _____ Phone: _____ Ext: _____

Fax: _____ Email: _____

Work Injury Contact: _____ Phone: _____ Ext: _____

Fax: _____ Email: _____

Billing Information

Contact: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Insurance Information

Workers' Compensation Carrier: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Policy #: _____

Injury Directives

Please check all that apply:

- Post-Accident Drug Screen Required
 Post-Accident Breath Alcohol Test Required

Substance Abuse Testing

Urine Drug Screening

Type of Drug Test (Check all that apply):

- Collection Only
 eScreen- DOT
 eScreen- Non DOT
 DOT (NIDA 5) Split Sample
 10 Panel Non DOT

Preferred Laboratory:

- Clinical Reference Laboratory
(Occupational Medicine Default)
 Other Lab (Please submit information below)
Lab Name: _____
Address: _____

Billing Address (if different from pg. 1)

Breath Alcohol Testing

Designated Employee Representative

Name: _____

Phone: _____

After Hours Contact

Name: _____

Phone: _____

Mail Results To:

Name: _____

Address: _____

Billing Address (if different from pg. 1)

Employee will bring drug kit at time of visit:

Yes No

Drug screen kits will be sent before employee's visit:

Yes No

Company's Authorized Contact for Drug Screen Results:

Name: _____

Notify by Email: _____

Mail Hardcopy: _____

Phone: _____

Physicals

Type of Physical (Check all that apply):

- Pre-Placement
- DOT
- Respirator
- Chemical Handler
- Hazardous Materials
- Return to Work

Authorized Contact for Physical Results

Name: _____

Address: _____

Email: _____

Phone: _____

Does your company provide paperwork for physicals?

- Yes
- No, I would like Occ. Med. to provide all paperwork.

Billing Address (if different from pg. 1)

Street Address: _____

City: _____ State: _____ Zip: _____

Additional Services

Please check all that apply:

Other Services

- Physical Therapy
- Worksite Ergonomic Assessment
- Safety Walk-through
- Flu Shots
- OSHA Audiogram
- Chest X-ray
- TB Skin Test
- Onsite Substance Abuse Testing
- Job Hazard Analysis
- Spirometry/Pulmonary Function
- Respirator Fit Testing
- Hair Analysis (SAT)
- Health Professional Profile (SAT)

Educational Programs

- CPR/First Responder
- Back Safety Seminar
- Blood Borne Pathogen
- Customized Seminars

Wellness Events

- Health Fairs
- Health Risk Appraisals
- Immunizations
- Customized Wellness Events

Please save your completed form and email it as an attachment to Occupational Medicine at patty.stovall@hcahealthcare.com. The form may also be faxed to (940) 384-4726.

If you have any questions, please feel free to contact us at (940) 384-3570.