

# Occupational Medicine- Industrial Work Service



Date:		
Contact Name:	Title:	
Company Name:		
Address:		
Ph:	Fax:	Email:

## OFFICE PERSONNEL:

Owner/Mgr:	Ph:
HR Director:	Ph:
Safety/Risk Manger:	Ph:
Contact for Drug Screen Results:	Ph:

## WORKERS COMPENSATION INFORMATION

Worker's Compensation Insurance Carrier:		Policy#:	
Billing Address:			
Phone:		Fax:	
Do you have a dedicated Case Manager(s)?		YES	NO
If yes, Provide Name(s):			

TPA/Risk Management Company (if different from above):	
Billing Address:	

Does your Work Comp Carrier / TPA access a Provider Network (i.e.: First Health)?	YES	NO
If yes, which network do they utilize?		
Is your company self-funded/self-insured?	YES	NO

Number of AZ Employees:	Number of locations (in AZ):
Address for AZ Locations:	

# Occupational Medicine- Industrial Work Service



Number of Injuries Last Year?
Most Common injuries:
Jobs in which these injuries occur:

Assistance Provided in Loss Prevention?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Safety Programs in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Components of Safety Program:		

Pre-employment functional capacity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	What Type?
ADA Compliance Programs:			

<b>Drug Screens:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>What Type(s)?</b> <input type="checkbox"/> Regulated <input type="checkbox"/> Non-Regulated
<b>Breath Alcohol:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Pre-Emp <input type="checkbox"/> Random <input type="checkbox"/> Post Accident
	<input type="checkbox"/> Reasonable Cause/Susp. <input type="checkbox"/> Return to Duty
Preferred Lab? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name:
<input type="checkbox"/> 5 panel <input type="checkbox"/> 10 Panel	(if left blank house lab will be used)
Who directs Medical Care? <input type="checkbox"/> Employer	<input type="checkbox"/> Case Manager/TPA <input type="checkbox"/> Other:

Presently Using:	<input type="checkbox"/> Occ Med. Clinic	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> MD Primary	<input type="checkbox"/> Hospital
------------------	--	--------------------------------------	-------------------------------------	-----------------------------------