

# New Company Information

MidMichigan Health

Company Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Billing Address (If different than above): \_\_\_\_\_

## Worker's Comp Carrier Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Company Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## Person(s) Responsible for Treatment Authorization

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Can individuals listed above receive test results and medical restrictions?  Yes  No

Comments: \_\_\_\_\_

## Services Typically Requested (Please mark all that apply)

### Physical Exam:

- Pre-Employment Physical
- DOT Physical
- Annual Physical
- Other (please specify) \_\_\_\_\_

### Drug Testing:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Non - DOT Drug Screen | <input type="checkbox"/> Non - DOT Breath Alcohol | <input type="checkbox"/> Collection Only         |
| <input type="checkbox"/> DOT Drug Screen       | <input type="checkbox"/> DOT Breath Alcohol       | <input type="checkbox"/> Drug Screen With Injury |
| <input type="checkbox"/> Hair Drug Collection  | <input type="checkbox"/> Saliva Alcohol Swab      |  |

### Other Services:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Audiogram (OSHA hearing test)          | <input type="checkbox"/> PFT                 | <input type="checkbox"/> Wellness Services               |
| <input type="checkbox"/> Respirator Fit Testing                 | <input type="checkbox"/> Hepatitis B Vaccine | <input type="checkbox"/> Health Screenings/Presentations |
| <input type="checkbox"/> Flu Shots                              | <input type="checkbox"/> TB Test             |  |
| <input type="checkbox"/> Worker's Compensation Injury Treatment | <input type="checkbox"/> Vision Screening    |  |



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