



Client Information

Company Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Title: _____

Phone: _____ FAX: _____

Email: _____

Type of Business: _____

Work Site Address: _____

City: _____ State: _____ Zip: _____

Employee population:

Full Time _____ Part-Time _____ Seasonal _____

Work Comp Carrier Information

Carrier Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact person: _____

Title: _____

Phone: _____ FAX: _____

Policy Number: _____

Desired Services (check all that apply)

- Acute injury care (after hours at HDH Emergency Department) or WORK HEALTH M-F 8-5)
- Follow-up care (at WORK HEALTH by appointment only)
- Case Management (coordination of care with assigned carrier/agency)
- Urine Drug Screens/Pre-Post (please describe specifics of testing needed in comment section)
- Breath Alcohol Testing (BAT)
- MRO interpretation (by contracted provider or designee)

Additional Services

- Pre-employment physicals (available M-F 8:00-4:00 by appointment only)
- Fit for Duty Exams
- DMV/DOT Physical Exams (we do not provide DOT lab tests at this facility)
- Job Descriptions (please provide as needed)
- Audiology testing (with OSHA approved sound booth/equipment)
- Eye exams (color testing for DMV and job specific duty)
- EKGs
- Stress Treadmill 12 lead EKG
- Back Screens to determine lift ability for specific job duty
- Work Station Evaluations (once approved by WC carrier)
- OSHA Respiratory Questionnaire reviews by physician or licensed staff
- Spirometry exams for respirator use at work approved by physician/licensed staff
- Onsite Services (for groups of 15 or more by appointment only)
- Interpretation Services
- Other _____

Notes/Additional Comments

Please submit this form online or mail to the address at the bottom of this form. A representative from the WORK HEALTH department will contact you to discuss contract agreements and pricing. Thank you for your interest in our services.