ACCT#: _______________

CORPORATE INFORMATION FORM

Occupational Health and Wellness

A Service of Houston Healthcare

2510 Highway 127, Kathleen, GA 31047

(478) 988-1853 Fax (478) 988-1858

COMPANY: ____

TYPE OF BUSINESS: ____

NUMBER OF EMPLOYEES: ____

ADDRESS: __________________________ CITY: _________________ S: ___ Z: _____

PHONE: _____________________________ FAX: _______________________________

CONTACT PERSON/TITLE: ____

ALTERNATE CONTACT PERSON: ____

WORKERS' COMP INSURANCE CARRIER: ____________________________________

CONTACT PERSON: __________________________ NUMBER: ___________________

ADDRESS: __________________________ CITY: _________________ S: ___ Z: _____

MAIL THE BILL TO: ____

CALL/MAIL RESULTS TO: ____

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1. Please list the physicians on your Workers' Compensation Panel of Physician so that we can make appropriate referrals as needed.

   Occupational Health & Wellness (478) 988-1853

   <u>Keith Abney, MD. Board Certified Occupational Medicine</u>

   Name Specialty Phone No.

   ____

   Name Specialty Phone No.

   ____

   Name Specialty Phone No.

   ____

   Name Specialty Phone No.

2. **SHOULD POST-INJURY DRUG SCREENING BE DONE? ______YES ______NO**
3. **SHOULD POST-INJURY BREATH ALCOHOL TESTING BE DONE? ______YES ______NO**
4. **PLEASE CHECK SERVICES TO BE UTILIZED:**

   [ ] WORKERS' COMPENSATION [ ] EXECUTIVE EXAMS [ ] POST-OFFER EXAMS
   [ ] RETURN TO DUTY EXAMS [ ] DOT EXAM [ ] RESPIRATOR CLEARANCE
   [ ] PULMONARY FUNCTION TEST [ ] AUDIOGRAMS [ ] ON-SITE SAFETY EVALUATIONS
   [ ] PHYSICAL THERAPY/REHAB [ ] FUNCTIONALITY TESTING [ ] ERGONOMIC EVALUATIONS
   [ ] HEALTH FAIRS [ ] ON-SITE EDUCATION [ ] ON-SITE NURSING
   [ ] BREATH ALCOHOL TEST [ ] BLOOD ALCOHOL TEST
   [ ] DOT (FEDERAL) DRUG SCREENS [ ] NON-DOT (FORENSIC) DRUG SCREENS

   Have Corporate contract with _____________Laboratories or ____ Use OHW Designated Lab.

   COC (Drug testing form) will be __ sent with patient or __ kept on File at OHW.

Please fax a completed copy of this form to (478) 988-1858 prior to sending in your first patient. Call (478) 988-1853 if you need assistance.

____ ___________________________

Signature of Company Representative Date