Occupational Medicine Company Profile

Company Name ______________________________

Address ______________________________

City ______________________ State ________ Zip Code__________

Primary Contact______________________ Title______________________

Phone Number______________________ Email Address______________________

Secondary Contact______________________ Title______________________

Phone Number______________________ Email Address______________________

After Hours/Emergency Contact______________________ Title______________________

After Hours Phone Number______________________ Email Address______________________

Preferred method of sending paperwork:

Send to the attention of ______________________________

Please indicate preferred method

- □ Secure Fax ______________________________
- □ Email ______________________________
- □ Mail ______________________________

Select which services your company will utilize and complete the corresponding information.

Employment Examinations

Please indicate which examinations you expect to utilize. This is for company protocol set-up only. Examinations will only be performed when indicated on the employee's Authorization for Treatment form.

- □ Pre-employment/Post offer Physical
- □ Non-DOT Drug Screen Collection
- □ Breath Alcohol Test
- □ DOT Physical
- □ DOT Drug Screen Collection
- □ Flu Vaccine
- □ COVID-19 Testing
- □ Respiratory Clearance Exam
- □ Respiratory Fit Test (bring your respirator)
- □ Pulmonary Function Test
- □ Audiometric Testing
- □ Vision Screening – Snellen
- □ Vision Screening – Color Blind testing
- □ Vision Screening – Titmus (Kernersville only)
- □ TB Skin Test
- □ TB Quantiferon Gold Blood Draw
- □ Tetanus Vaccine
- □ Hepatitis B Vaccine
- □ Hepatitis B Titer
- □ Rabies Vaccine
- □ Rabies Titer

Other: ______________________________

Drug Screening – Collection Only

You must provide us with your company's chain of custody form including the laboratory and Medical Review Officer information. Below are a few options if you have not already selected a lab/MRO. Please note: We cannot collect any specimens without a chain of custody form. Some of the options below use electronic chain of custody forms and web-based reporting options for your convenience.

□ Wolfe, Inc., 828-514-2863 □ Coe Management Group, 336-768-9628 □ Quest Diagnostics, 866-697-8378

Workers Compensation

1. Would you like employees with a Workers' Compensation claim undergo a drug test on their initial visit? □ No □ Yes This testing must be performed within 32 hours of the incident.

2. Would you like employees with a Workers' Compensation claim undergo a breath alcohol test on their initial visit? □ No □ Yes This test must be performed within 8 hours of the incident.

3. Who should bill for Workers' Compensation Services?
   □ Company □ Carrier □ Third Party Administration
   □ Other ______________________________

I authorize Wake Forest Baptist Health to use my company logo in marketing of their Occupational Medicine services. ______ (initial)

Workers Compensation Insurance (Please note, if you do not provide us with insurance carrier information, the company will be responsible for all bills.)

Carrier ______________________________ Policy ______________

Address ______________________________

City ______________________________ State ________ Zip Code __________

Phone Number ______________________________

Preferred Pharmacy ______________________________

Third Party Administrator (TPA)

Address ______________________________

City ______________________________ State ________ Zip Code __________

Phone Number ______________________________

Special Instructions? ______________________________

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By signing below I confirm that I am an authorized company representative with the authority to provide the information contained in this form, and that all information is accurate to the best of my knowledge.

Signature ______________________________ Date ______________________________

Return form to Lindsey Leonard at:

Email: OccHealthBilling@wakehealth.edu OR Fax: 336-716-4941

Mail: Wake Forest Best Health For Business - 5th floor Attn: Lindsey Leonard
486 N. Patterson Ave Winston-Salem, NC 27101