



## Department of Workers Compensation EMPLOYER PROFILE

Company Name:

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Work Comp. Contact(s): \_\_\_\_\_  
(First Name, Last Name)

After Hours Contact(s): \_\_\_\_\_

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

e-mail Address:

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

\* \* \*

Billing Address If Different From Above:

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Billing Contact:

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



**Department of Workers Compensation  
EMPLOYER PROFILE**

**REPORT RESULTS TO:**

\_\_\_\_\_ (First Name, Last Name)

Report Results via:

Fax: \_\_\_\_\_

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

Mail Results to: \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE: (PLEASE FILL OUT OR ATTACH A COPY OF INSURANCE POLICY).**

Worker's Comp Insurance or Third Party Company: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_

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

\_\_\_\_\_  
**Authorized Representative Signature** **Date**

*PLEASE CHECK ALL ITEMS AND PROCEDURES THAT YOU REQUIRE FOR YOUR EMPLOYEE.*



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### WORKER'S COMPENSATION: (WHEN YOUR EMPLOYEE GETS HURT)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Would you like our Work Comp Staff to call for prior authorization: <ul style="list-style-type: none"> <li><input type="radio"/> Always required</li> <li><input type="radio"/> As requested</li> </ul> | <input type="checkbox"/> Modified Duties available(Recommended this be offered)<br><br><input type="checkbox"/> No Modified Duties Available | <input type="checkbox"/> Post Accident/Injury Drug Screen <ul style="list-style-type: none"> <li><input type="radio"/> Always required</li> <li><input type="radio"/> As requested</li> </ul><br><input type="checkbox"/> Post Accident / Injury B.A.T. <ul style="list-style-type: none"> <li><input type="radio"/> Always required</li> <li><input type="radio"/> As requested</li> </ul> |
| <input type="checkbox"/> Lab: <ul style="list-style-type: none"> <li><input type="radio"/> _____</li> <li><input type="radio"/> Lab Reqs provided</li> </ul>   |  |   |

### EMPLOYMENT ROUTINE SCHEDULED EXAMS:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Basic Physical Exam                             | <input type="radio"/> Send to lab for confirmation                  | <input type="checkbox"/> TB/PPD Skin Test                |
| <input type="checkbox"/> DMV/DOT Physical Exam                           | <input type="radio"/> Contact Employer                              | <input type="checkbox"/> Chest X-Ray to rule out TB Test |
| <input type="checkbox"/> Range of Motion / Back Exam                     | <input type="checkbox"/> Non-DOT Drug Screen (What Company/ Forms?) | <input type="checkbox"/> Spirometry/PFT                  |
| <input type="checkbox"/> Back X-Ray                                      | <input type="checkbox"/> DOT Drug Screen                            | <input type="checkbox"/> Chest X-Ray                     |
| <input type="checkbox"/> EKG   | <input type="checkbox"/> Hair Follicle Collection                   |  |
| <input type="checkbox"/> Hepatitis B Series                              | <input type="checkbox"/> Non-DOT Breath Alcohol Test                |  |
| <input type="checkbox"/> Audiogram                                       | <input type="checkbox"/> DOT Breath Alcohol Test                    |  |
| <input type="checkbox"/> Rapid 5-Panel Drug Screen For positive results: |   |  |