

OCCUMED ACCOUNT INFORMATION SHEET

Client Information

Company Name: _____

Address: _____

Tax Identification Number: _____

Contact Person: _____

Telephone Number: _____

Fax Number: _____

Email: _____

Please provide the following:

Trade References:

1. Name: _____

Address: _____

Phone Number: _____

Account Number: _____

Contact Person: _____

2. Name: _____

Address: _____

Phone Number: _____

Account Number: _____

Contact Person: _____

3. Name: _____

Address: _____

Phone Number: _____

Account Number: _____

Contact Person: _____

OCCUMED WORKERS COMPENSATION INSURANCE INFORMATION

Company Name: _____

Address: _____

Contact Person: _____

Telephone Number: _____

Fax Number: _____

Policy Number: _____

When an employee is injured on the job, would you like for us to

Drug test them on their first visit to the clinic? YES NO

Do you intend to use our facility for any of the following?

_____ Pre-employment drug testing

_____ NIDA drug testing

_____ Worker's Compensation Accidents

_____ DOT Physicals

_____ TB Testing

_____ Random drug testing

_____ Flu vaccinations

_____ Pre-employment physicals

_____ Hepatitis B vaccinations

_____ Etc. _____