NorthOaks
Occupational Health Services

# COMPANY SERVICE PROFILE

**Company's Name:** _____

**Phone Number:** _____

**Secured Fax Number:** _____

**Address:** _____

_____

_____

**Main Contact Person:**
(responsible for service-related questions)

_____

**Contact Phone Number:** _____

**Contact Email:** _____

**Contact Secured Fax:** _____

## DESIGNATED EMPLOYER REPRESENTATIVE (DER)

(manages employee screening results: ☐ check if same as Main Contact )

**DER Name & Title:** _____ **Email:** _____

**Office Phone:** _____ **Secured Fax:** _____

## BILLING INFORMATION

**Accounts Payable Contact Person's Name:** _____

**Phone Number:** _____

**Fax Number:** _____

**Billing Address:** _____

_____

_____

**Tax ID/FEIN:** _____

## WORKERS' COMPENSATION INFORMATION

(If not applicable, choose: ☐ N/A)

**Workers' Compensation Carrier:** _____

**Address:** _____

_____

_____

**Policy Number:** _____

**Phone Number:** _____

**Fax Number:** _____

## SCOPE OF SERVICES TO BE UTILIZED:

☐ **Physicals** ☐ **CDL Physical** ☐ **Injury Treatment** ☐ **Immunizations**

☐ **Drug Screens** ☐ **eScreen Collection** ☐ **Breath Alcohol** ☐ **Lab Services**

☐ **Audiograms** ☐ **Vision Testing** ☐ **Pulmonary Function Testing**

☐ **Other services:** _____

**For every pre-employment physical, include:** ☐ **Breath Alcohol Test** ☐ **Urine Drug Screen**

☐ **Other Services** _____

**At each instance of treating a work related injury:** ☐ **Breath Alcohol Test** ☐ **Urine Drug Screen**

☐ **Other Services** _____

**For Drug Screens, use North Oaks MRO Services:** ☐ **Yes** ☐ **No**

**Print Name:** _____ **Date:** _____

**Signature:** _____

**NOTES**

NORTHOAKS
Occupational Health Services

*If you have any questions, please call (985) 230-5726*
*or email ohs@northoaks.org.*