NorthOaks
Occupational Health Services

COMPANY PROFILE

Company Name: _____

Phone Number: ( ) _____ **Contact Person:** _____

Secured Fax Number: ( ) _____ **Contact Phone Number:** ( ) _____

Address: _____ **Personnel authorized to give or receive information:**

_____ _____

_____ _____

_____

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Carrier: _____

Address: _____ **Policy Number:** _____

_____ **Phone Number:** ( ) _____

_____ **Fax Number:** ( ) _____

Please Select One:

- ☐ Mail Insurance form directly to Worker's Compensation carrier.
- ☐ Mail insurance form to company who will forward to Workers' Compensation carrier.

BILLING INFORMATION

Billing Contact: ( ) _____ **Phone:** ( ) _____

Address: _____

_____

Does your company have a light-duty program? ☐ **Yes** ☐ **No**

Services required for pre-employment, in addition to physical: ☐ **Breath Alcohol Test** ☐ **Urine Drug Screen**

Serviced required for a work-related injury, in addition to treatment: ☐ **Breath Alcohol Test** ☐ **Urine Drug Screen**

Give original of CDL physicals to employee? ☐ **Yes** ☐ **No**

Send copy of CDL via: ☐ **Fax** ☐ **Mail** ☐ **With employee**

Authorized Signature: _____ **Date:** _____

LAB INFORMATION

☐ **North Oaks provides Lab**

☐ **Collection Only**

Lab Name: _____ Phone: ( ) _____

Lab Address: _____ Fax: ( ) _____

_____

MEDICAL REVIEW OFFICER (MRO) INFORMATION

☐ **North Oaks provides MRO**

☐ **Other**

MRO Name: _____ Phone: ( ) _____

MRO Address: _____ Fax: ( ) _____

_____

Direct Reporting of non-DOT negative drug screen results is available to clients utilizing our MRO services. If your company will take advantage of this service, please complete below.

Send Results to: (choose one)

☐ **Email**

Contact: _____

Phone: ( ) _____

Email Address: _____

☐ **Fax**

Contact: _____

Phone: ( ) _____

Fax: ( ) _____

**** All Chain of Custody forms will be faxed to the secured fax number listed on the front page.**

**** If CDL cards are needed for your company, they must be provided to us.**

AVAILABLE SERVICES

Date:_____ **Company:** _____

SERVICE REQUESTED	PRICE
☐ Physical (Non-DOT)	_____
☐ Physical (DOT)	_____
☐ Urine Drug Screen (Non-DOT)	_____
☐ Urine Drug Screen (DOT)	_____
☐ Quick-check	_____
☐ Collection Only	_____
☐ Breath Alcohol Test (Non-DOT)	_____
☐ Breath Alcohol Test (DOT)	_____
☐ 12-Lead EKG	_____
☐ Pulmonary Function Test	_____
☐ X-Ray _____	_____

Inoculations

☐ Flu Vaccine	_____
☐ Hepatitis B	_____
☐ TB Skin Test	_____
☐ Tetanus/Diphtheria	_____
☐ Rubella Titer	_____
☐ HBS/ABQN	_____
☐ Other _____	_____

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