EMPLOYER APPLICATION – NEW CLIENT

Submitted by: 		**Date:** Click here to enter a date.

Company information:

Company name:			
Address 1:		Address 2:	
City:		State:	Zip:
County:	Phone:	Ext:	Fax:
Email:		Secure fax:	
Main contact:			
Alias name (another name your employees may use to refer to your company):			
Parent employer:			

Company billing account information (if different):

Account name (if different from company name):		
Address 1:	Address 2:	
City:	State:	Zip:
Contact name:		

Company Contacts:

First name:		Last name:
Title:		
Phone:	Ext:	Fax:
Cell:	Email:	
Contact type: Primary Contact		
Notes: (e.g., "Do not contact directly" or "Email contact preferred," etc.) Click here to enter text.		

First name:		Last name:
Title:		
Phone:	Ext:	Fax:
Cell:	Email:	
Contact type: Primary Contact		
Notes: (e.g., "Do not contact directly" or "Email contact preferred," etc.) Click here to enter text.		

Special Billing Instructions

Optional: list any special billing instructions here (e.g., "all First Aid bills go directly to carrier," or "Please send bills on CMS 1500 forms only," etc.)

Click here to enter text.

Workers' Comp Information

Self insured for workers' comp ☐ if you check this box, you do not need to fill in any other billing information. We will automatically bill to your company directly.

Company name for workers' comp billing:			
Address line 1:		Address line 2:	
City:		State:	Zip:
Phone:	Ext:	Fax:	
Policy number:		Effective:	Exp date:

All required if checkbox at the top is not checked, except address line 2

Carrier or TPA contacts (optional):

First name:		Last name:
Title:		
Phone:	Ext:	Fax:
Cell:	Email:	
Contact type: ☐ Primary ☐ Secondary		
Notes: (e.g., "Do not contact directly" or "Email contact preferred," etc.) Click here to enter text.		

Not required

First name:		Last name:
Title:		
Phone:	Ext:	Fax:
Cell:	Email:	
Contact type: ☐ Primary ☐ Secondary		
Notes: (e.g., "Do not contact directly" or "Email contact preferred," etc.) Click here to enter text.		

Not required

LAB or TPA Billing

LAB or TPA billing—If your company wants all drug screens billed to the lab or TPA, indicated the information below:

Name of company to be billed: ☐ LAB ☐ TPA		
Address line 1:		
Address line 2:		
City:	State:	Zip:
Phone:	Email:	Secure fax:
Parent organization (e.g., a national organization):		
Main contact:		
Contract level:	Contract definition:	

LAB/TPA contacts:

Contact first name:		Last name:	
Title:		Department:	
Address line 1:			
Address line 2:			
City:		State:	Zip:
Phone:	Ext:	Fax:	
Cell:		Email:	
Contact type: ☐ Primary ☐ Secondary			
Notes: (e.g., "Do not contact directly" or "Email contact preferred," etc.) Click here to enter text.			

Reporting for Occupational Services:

Reporting Method:		
☐ Physicals	☐ Drug Testing	Worker's Comp (see below)
Reporting: Check reporting method preferred. (Worker's Comp reporting is offered through or Employer Web portal- this portal allows 24/7 access to work status reports for all injured workers, please contact Office Manager to request access!)		
☐ Auto Fax:	☐ Email:	☐ Employee record

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☐ Auto Fax:	☐ Email:	☐ Employee record

Company Protocols:

Please note we are unable to render services without a completed Notification Form.

Physicals: Check those that apply. *(we will use our clearance forms unless otherwise specified)*		
☐ Post Offer Physical	☐ DMV/DOT Physical	☐ Respirator Clearance Exam
☐ Level 5 Physical	☐ Fitness for Duty	☐ Own Phys Form *(please attach physical form when returning this application)*
Reporting: Check reporting method preferred.		
☐ Auto Fax:	☐ Email:	☐ Employee record

Drug Screens: Check those that apply.				
☐ DOT ☐ NON-DOT *(DOT- Department of Transportation is a federal government agency)*				
☐ Drug Collection Only (Company Chain of Custody)	☐ Drug Collection/Testing *(Medical Center of Marin Chain of Custody)*	☐ Breath Alcohol Test	☐ Hair Follicle Test	☐ Instant 5 Panel ☐ Instant 10 Panel
Reporting: Check reporting method preferred.				
☐ Auto Fax:	☐ Email:	☐ Employee record		

Vaccines & Titers: Check those that apply. *(There is a venipuncture fee for all blood work)*		
☐ MMR Vaccine	☐ Influenza Vaccine	☐ Varicella Titer
☐ Hepatitis B Vaccine	☐ TDaP Vaccine	☐ Hepatitis B Titer
☐ Varicella Vaccine	☐ MMR Titer	☐ Other: ______________

Miscellaneous Services: Check those that apply. *(There is a venipuncture fee for all blood work)*		
☐ TB/PPD Skin Test	☐ Chest X-Ray *(1 view)*	☐ Mask Fit Test
☐ Quantiferon Gold *(Tb Blood Test)*	☐ Chest X-Ray *(2 view)*	☐ Spirometry
☐ TB Risk Assessment	☐ Lumbar X-Ray *(2 view)*	☐ EKG
☐ Audiometry *(Basic)*	☐ Audiometry *(Extended)*	☐ Blood Lead/ZPP
☐ CBC *(complete blood count)*	☐ CMP *(Chem 20)*	☐ Other: ______________