41715 Winchester Road Ste 101 Temecula, CA 92590 | Ph: 951.308.4451 | Fax: 951.2960099
www.temecula24hoururgentcare.com

Department of Workers Compensation

EMPLOYER PROFILE

Company Name: ____

Contact(s): ____

Address: ____

Phone: ______________________________ Fax: ________________

* * * * *

Billing Address: ____

Billing Contact: ____

e-mail Address: ____

Phone: ______________________________ Fax: ________________

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

WORKER'S COMPENSATION

- Always call for prior auth
- No prior Auth required
- Post Accident/Injury Drug Screen
  - Always required
  - As requested
- Modified Duties Available
- No Modified Duties Available

EMPLOYMENT EXAMS

- Basic Physical Exam
- DMV/DOT Physical Exam
- Range of Motion / Back Exam
- Back X-Ray
- EKG
- Rapid 5-Panel Drug Screen
- Non-DOT Drug Screen
- DOT Drug Screen
- Hair Follicle Collection
- Non-DOT Breath Alcohol Test
- DOT Breath Alcohol Test
- TB/PPD Skin Test
- Spirometry/PFT
- Chest X-Ray
- Hepatitis B Series
- Audiogram

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Department of Workers Compensation

REPORT RESULTS TO:

____
(First Name, Last Name)

Report Results via:

Fax: ______________________________

Phone: ____________________________

Mail Results to: ____

Special Instructions: ____

INSURANCE

Worker's Comp Insurance or Third Party Company:

____

Insurance Address: ____

Policy Number: ____

Phone: ____ Fax: ________________________________

____

Authorized Representative Signature **Date**

Please complete this form and fax it back to 951.506.0992

*Last updated 1/11/2011