Franciscan WORKING Well

***required field**

COMPANY PROFILE

(Se Habla Español)

**Company:* ______________________ **Employees:* ______________________

**Address:* ______________________ **Hours:* ______________________

**City:* ____________ *State:* ______ *Zip:* ______ **Business Type:* ______________________

**Phone:* ____________ *Ext:* ______ *Fax:* ______ **E-mail:* ______________________

**Contact:* ______________________ **Web Site:* ______________________

**Workers' Comp After Hours Contact:* ______________________ ** Phone:* ______________________

****Bill to Company Address for:*** ☐ *Physical* ☐ *Drug/Alcohol* ☐ *Post Accident Drug Screen/BAT* ☐ *Injury* ☐ *Miscellaneous*

Special Billing Instructions: ______________________

DRUG & ALCOHOL TESTING REQUIREMENTS

		Pre-Placement	Post-Accident	Random	Reasonable Cause
Non-DOT ☐ 5 ☐ 10 ☐ 10 +Oxy ☐ 10+Ecs		☐	☐	☐	☐
DOT		☐	☐	☐	☐
TestCup 5 ☐	10* ☐	☐	☐	☐	☐
Hair Analysis		☐	☐	☐	☐
BAT		☐	☐	☐	☐

BAT Saliva Approved ☐ *Yes* ☐ *No*

Collection Only: ____________ *Type :* ____________ *TPA or Lab:* ____________ *Employee Bring Kit:* ____________

TPA or Lab Address: ______________________ *Phone:* ____________ *Ext:* ______

DER Contact: ______________________ *Phone:* ____________ *Ext:* ______

After Hours: ☐ *Yes* ☐ *No* ______________________ *Ext:* ____________ *Type:* ______

After Hours Special Instructions: ______________________

Send Results to: ____________ *Email:* ____________ *Fax:* ____________

Escreen Auto Fax: ☐ *Yes* ☐ *No* *Contact:* ______________________ *Fax:* ____________

Escreen My 123: ☐ *Yes* ☐ *No* *Contact:* ______________________ *Fax:* ____________

☐ *MAIL TO COMPANY:* ______________________

☐ *MAIL TO OTHER:* *Company Name/Address* ______________________

☐ *On-Site After Hours Drug Screen Program* ☐ *Drug Screen Random Program*

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PHYSICAL EXAMINATIONS AND SCREENINGS

Circle Choice:

DOT ***Non-DOT*** ***Return to Work*** ***Fit for Duty***

☐ *PFT* ☐ *Respiratory Questionnaire* ☐ *Respirator Fit Testing* ☐ *Audiogram* ☐ *Mini Functional Eval*

☐ *Lifting # of Pounds* ________ ☐ *PPD* ☐ *X-Ray*

☐ *Check box if needs to be in PX Category*

Routine Surveillance: ____________________

Respirator Clearance: ____________________

Vaccines: ____________________

Titers: ____________________

Send Results to: ____________ *Email:* ____________ *Fax:* ________

Special Instructions or TPA billing ____________________

Company Forms to be used: ____________________

INJURY TREATMENT SERVICES

☐ Work Comp New ☐ Work Comp Recheck

Workers' Comp Special Instructions: ____________________

☐ *Limited Duty* ☐ *No Limited Duty* ☐ *Call for Instruction* ☐ *Provider to call:* ____________

Send 'Work Status' Form to: ____________ *Fax:* ____________ *Email:* ____________

Workers' Comp Carrier: ____________________ ☐ *Self-Insured*

Address: ____________ *City:* ____________ *State:* ______ *Zip:* ______

Contact: ____________ *Phone:* ____________ *Ext:* ______ *Fax:* ______

ADDITIONAL INSTRUCTIONS

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☐ *Crown Point* ☐ *Hammond* ☐ *Michigan City* ☐ *Munster* ☐ *Portage -The Port* ☐ *Portage-Willowcreek* ☐ *Rensselaer* ☐ *Valpo-La Porte Ave* ☐ *Valpo-Rt. 30*

Date and Initial ____________________ ☐ New ☐ Update ☐ Upsell