WORKMEN'S COMPENSATION INFORMATION

Company Name (Employer): _____

Mailing Address: _____

_____

Billing Address: _____

_____

Phone Number: _____ _____
Primary Secondary

Fax Number: _____ _____
Primary Secondary

Contact Person(s): _____

Insurance Carrier: _____

Policy Number: _____

Carrier's Address: _____

_____

Carrier's Phone Number: _____

Carrier's Fax Number: _____

Contact Person (If Available): _____

Do you require Drug Screening (Post-Accident, Pre-Employment and/or Random)?** _____
In-House Test or MRO (Chain of Custody)?** _____
Do you require Alcohol Breath Testing? _____ In-House or MRO? _____
Do you offer Light-Duty for injured employees? _____

Authorized By: _____ Date: _____ Employee: _____

**This is not covered by WorkComp and will be billed to the employer*

We offer a 5 or 10 panel, in-house Clia-waived Urine Drug Screen.

Most national chains require a "Chain of Custody" UDS.

12/13/2010