



**NEW COMPANY INFORMATION:**

COMPANY NAME \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

CONTACT NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

COMPANY ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

**ADDITIONAL CONTACTS:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
NAME \_\_\_\_\_ PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
NAME \_\_\_\_\_ PHONE \_\_\_\_\_ CELL \_\_\_\_\_

**PROTOCOL TYPES:**

WORK-COMP  EMPLOYER PAID SERVICES (EPS)

**ADDITIONAL TESTING:**

**DRUG SCREEN:**  YES  NO

***REASON:***

POST-ACCIDENT  ALL INJURIES  ONLY IF REQUESTED  
 PRE-EMPLOYMENT  RANDOM  REASONABLE SUSPICION

***TYPE:***  5 PANEL NIDA(DOT)  5 PANEL NON-NIDA  10 PANEL NON-NIDA

**BREATH ALCOHOL:**  YES  NO

***REASON:***

POST-ACCIDENT  ALL INJURIES  ONLY IF REQUESTED  
 PRE-EMPLOYMENT  RANDOM  REASONABLE SUSPICION

***TYPE:***  NIDA(DOT)  NON-NIDA

**HOW DO YOU WANT TO GET RESULTS?**

WEB-BASED  EMAIL  FAX  MAIL

**HOW DO YOU WANT TO GET TRANSCRIPTIONS AND RETURN TO WORK FORMS?**

EMAIL  FAX  MAIL

**WORK-COMP INFORMATION:**

INSURANCE CARRIER: \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

PHONE \_\_\_\_\_ FAX \_\_\_\_\_