

OCCUMED Workers Compensation Insurance Information

Company Name: _____

Address: _____

Contact Person: _____

Telephone Number: _____

Fax Number: _____

Policy Number: _____

When an employee is injured on the job, would you like for us to
drug test them on their first visit to the clinic? YES NO

Do you intend to use our facility for any of the following?

- _____ Pre-employment drug testing
- _____ NIDA drug testing
- _____ Worker's Compensation Accidents
- _____ DOT Physicals
- _____ TB Testing
- _____ Random drug testing
- _____ Flu vaccinations
- _____ Pre-employment physicals
- _____ Hepatitis B vaccinations
- _____ Etc. _____