ST. Anthony's

St. Anthony's Medical Center
Employer Profile

Company

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Contact Name: _____

E-Mail Address: _____

Insurance Carrier

Name: _____

Mailing Address: _____

_____

Phone: _____ Fax: _____ Contact: _____

Billing: ☐ Send Bill to Company Address ☐ Send Bill to Insurance Co.

Drug Screen	**DOT** ☐ **Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause**	**Non-DOT** ☐ **Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause**
Breath Alcohol	**DOT** ☐ **Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause**	**Non-DOT** ☐ **Post Accident** ☐ **Random** ☐ **Replacement** ☐ **Suspicion/Cause**
Physical Exam	☐ **Physical Exam** ☐ **DOT Exam** ☐ **Return to work/Fit for duty**	
Immunizations	☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **PPD**	

Special Instructions: