

Please complete this form then fax to Occupational Medicine @ 314-892-8532

St Anthony's Urgent Care Employer Profile Sheet

Company Demographics

Date:			
Company Name:			
Address:		City:	State: Zip Code:
Phone:	Fax:	email:	

Contact Information

1. Name:		email:
Title:	Phone:	Fax:
2. Name:		email:
Title:	Phone:	Fax:

Billing Information

Where do you want us to send the Workers' Compensation Bills? (select one)

_____ Company Address _____ Headquarters _____ Insurance Company

Company Headquarters/Main Office		
Address		
Phone	Fax	W/C Contact:

Worker's Compensation Insurance Carrier		
Policy #	Effective Dates	
Mailing Address		
Phone	Fax	Contact

Services Needed

Urine Drug Screen <input type="checkbox"/> Yes <input type="checkbox"/> No Br. Alcohol Screen <input type="checkbox"/> Yes <input type="checkbox"/> No Collection Only <input type="checkbox"/> Yes <input type="checkbox"/> No	What Type(s) <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> PPE <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Reasonable Cause/Suspicion
If yes, name of lab & company account number:	
Preplacement physical	<input type="checkbox"/> Yes <input type="checkbox"/> No
Annual Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No
DOT Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hep A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hep B	<input type="checkbox"/> Yes <input type="checkbox"/> No
PPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will these services be company paid or patient paid?	