

# Corporate Protocol Information Sheet

COMPANY NAME: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY, ST, ZIP: \_\_\_\_\_

## DESIGNATED CONTACT

### CONTACT #1

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_

CELL: \_\_\_\_\_

FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

### CONTACT #2

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_

CELL: \_\_\_\_\_

FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

Are you a WORKERS COMP SUBSCRIBER? \_YES \_NO

Do you have a case manager or corporate injury management program in place?  
\_YES \_NO

Please provide us with your injury management contact:

\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE REPRESENTATIVE:**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**CELL:** \_\_\_\_\_

**FAX:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

Does your company offer Light Duty?       **YES**    **NO**

Do you require a Post-Accident Drug Screen?       **YES**    **NO**

If Yes, please check the following drug screens required – provide us with details on your drug screening process.

- DOT UDS PRE-EMPLOYMENT**                       **Non-DOT UDS PRE-EMPLOYMENT**
- DOT UDS RANDOM**                                       **Non-DOT UDS RANDOM**
- DOT UDS POST-ACCIDENT**                               **Non-DOT UDS POST-ACCIDENT**
- BAT RANDOM**     **HAIR COLLECTION**
- BAT PRE-SCREEN**
- BAT POST-ACCIDENT**

**OTHER:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your company participate in a **Drug Surveillance** Program?  **YES**  **NO**

If yes, please provide the name and contact information:

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Do you have a preference in Abilene Emergency Rooms?  **YES**  **NO**

**ABILENE REGIONAL ER**  **HMC ER**  **WEST TEXAS HOSPITAL ER**  **EITHER, NO PREFERENCE**

**PLEASE PROVIDE YOUR FAX NUMBER FOR WORK INJURY & CORPORATE SERVICES REPORTS:**

**FAX:** \_\_\_\_\_

**SPECIAL REQUEST:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Please attach any additional corporate information you feel would be pertinent information so the Health Care Provider can better service your company's needs. E.g. health and safety programming, job descriptions and company mandated protocols)**

## **CORPORATE SERVICES**

The Occupational Medicine and Health Program offers a variety of services for the corporate sector that assist with pre-employment screening, maintaining healthy employees, and providing Occupational Health and Wellness education to your company. We conduct all areas of corporate physicals and employee screening. Please check components which you currently use or expect to use in the future. Please contact the Occupational Program Manager for further information or special request not listed below regarding corporate services.

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Corporate Drug Screening</b>           | <input type="checkbox"/> <b>Resting EKG, X-Ray</b>                             |
| <input type="checkbox"/> <b>DOT or NON-DOT Physicals</b>           | <input type="checkbox"/> <b>Pulmonary Function Testing</b>                     |
| <input type="checkbox"/> <b>Post-Offer Physicals</b>               | <input type="checkbox"/> <b>Hearing and/or Vision Screening</b>                |
| <input type="checkbox"/> <b>Physical Demands Assessment</b>        | <input type="checkbox"/> <b>Fit—For—Duty Programs</b>                          |
| <input type="checkbox"/> <b>Pre-Employment or Annual Physicals</b> | <input type="checkbox"/> <b>Return-To-Work Programs</b>                        |
| <input type="checkbox"/> <b>Respiratory Testing and Exams</b>      | <input type="checkbox"/> <b>MRO Service (Certified Medical Review Officer)</b> |

(UPON COMPLETION PLEASE SIGN BELOW AND FAX IMMEDIATELY  
TO (325) 795-9537 TO BE PROCESSED)

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Company Representative Signature

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Date Signed

**ATTN: OCCUPATIONAL MEDICINE**

C/o Stacy Garley, CTRS

Program Manager

PH: (325) 795-1888 ext. 104 CELL: (325) 260-5606 FX: (325) 795-9537

E-Mail: [sgarley@spineabilene.com](mailto:sgarley@spineabilene.com)

Web Address: [www.spineabilene.com](http://www.spineabilene.com)

**(BELOW TO BE COMPLETED BY SPINEABILENE OCCMED REPRESENTATIVE)**

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**Please note this is not a contract.**

The information you provide will be used to assist with communicating and assisting your company with occupational medicine and health corporate services along with assisting your and your employee with work injury management within our facility. Please contact the Occupational Medicine Program Manager if you have questions or need further information regarding our services at SpineAbilene Occupational Medicine.

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SpineAbilene OCCMED Signature

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Date Received