Reset All

www.qualityuc.com

EMPLOYER PROFILE FORM

Date Completed : ____________________

Completed by: ______________________

COMPANY INFORMATION

☐ New Account ☐ Update

Company Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Phone: ____________________ Fax : ____________________

Email: ____________________

Company Industry/Trade: ____________________ Number of Employees: ____________________

☐ *Company has multiple locations (Please provide a list of locations)*

COMPANY CONTACTS

Name: ____________________ Title: ____________________

Phone: ____________________ Ext: __________

Cell: ____________________

Fax: ____________________

Email: ____________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

Name: ____________________ Title: ____________________

Phone: ____________________ Ext: __________

Cell: ____________________

Fax: ____________________

Email: ____________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

Name: ____________________ Title: ____________________

Phone: ____________________ Ext: __________

Cell: ____________________

Fax: ____________________

Email: ____________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

www.qualityuc.com

OCCUPATIONAL SERVICES

Company Name: _____

Date Completed : _____

Completed by: _____

OCCUPATIONAL SERVICES BILLING:

Occupational Billing Contact:	Billing Address (if different than physical address):
Name: _____	Address: _____
Phone: _____ Ext: _____	City/State: _____
Email: _____	Zip: _____

Consortium or third party administrator (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

☐ **I do not use a consortium or third party administrator, bill company.**

Treatment Authorization Required : ☐ **Yes** ☐ **No**

SERVICES:

Physicals

- ☐ Post Offer Physical (Job Description Required)
- ☐ DOT Physical
- ☐ Respirator Physical
- ☐ Non Dot Physical

Ancillary

- ☐ Audiogram
- ☐ Vision
- ☐ PFT/Spirometry
- ☐ Respirator Fit Test

TB Testing*

- ☐ Quantiferon (TB Gold)
- ☐ Chest X-Ray

NON-DOT Drug Testing

Pre-Employment

- ☐ Hair Drug Test
- ☐ Non-DOT 5 Panel
- ☐ Non-DOT 10 Panel
- ☐ Rapid 5 Panel
- ☐ Rapid 10 Panel
- ☐ Collection Only

Random

- ☐ Hair Drug Test
- ☐ Non-DOT 5 Panel
- ☐ Non-DOT 10 Panel
- ☐ Rapid 5 Panel
- ☐ Rapid 10 Panel
- ☐ Breath Alcohol
- ☐ Collection Only

For Cause/ Reasonable Suspicion

- ☐ Hair Follicle
- ☐ Non-DOT 5 Panel
- ☐ Non-DOT 10 Panel
- ☐ Rapid 5 Panel
- ☐ Rapid 10 Panel
- ☐ Breath Alcohol
- ☐ Collection Only

DOT Drug Testing

- ☐ DOT Drug Test
- ☐ DOT Breath Alcohol Test

DOT Testing Agency		DOT Testing Authority
☐ FMCSA	☐ FTA	☐ DOT
☐ FAA	☐ PHMSA	☐ HHS
☐ FRA	☐ USCG	☐ NRC

Reasons for DOT Drug Testing (Check all that apply)

- ☐ Pre-Employment
- ☐ Random
- ☐ Return to Duty
- ☐ For Cause
- ☐ Reasonable Suspicion
- ☐ Other

www.qualityuc.com

WORKERS COMP SERVICES

Company Name: _____

Date Completed : _____

Completed by: _____

WORKERS' COMPENSATION BILLING:

Workers Comp Billing Contact:	☐ **Non- Subscriber (Do not have Workers Comp insurance)**
Name: _____	Address: _____
Phone: _____ Ext: _____	City/State: _____
Email: _____	Zip: _____

Workers Comp Insurance (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Are you in a Network? ☐ Yes ☐ No Please indicate name of Network: _____

WORKERS COMP INFORMATION

Does your company offer Modified Duty for injured workers?	☐ Yes	☐ No
Will a supervisor / manager bring in injured workers?	☐ Yes	☐ No
Are there any company specific forms that need to be completed for work related injuries? *(If answer is yes, please provide a copy for review)*	☐ Yes	☐ No
Does your company complete an OSHA 300 log?	☐ Yes	☐ No
Does your company use a Third Party Administrator (TPA) or Professional Employer Organization (PEO) to manage work related injuries?	☐ Yes	☐ No

- **If answer is yes to previous question, please provide TPA/PEO information below:**

TPA/PEO (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____ Email: _____

POST ACCIDENT DRUG & ALCOHOL TESTING SERVICES

Drug Tests		**Breath Alcohol Tests**	
☐ 5 Panel Non-DOT	☐ 5 Panel Rapid	☐ Hair Follicle	☐ DOT BAT
☐ 10 Panel Non-DOT	☐ 10 Panel Rapid	☐ DOT	☐ Non– DOT BAT

☐ **Drug testing is required for all injuries**	☐ **Drug testing when requested only**
☐ **Breath Alcohol testing is required for all injuries**	☐ **Breath Alcohol when requested only**