US MED URGENT CARE
Occupational Medicine Program
Dedicated to the total health of your workforce

Occupational Medicine Program
Phone: 808.456.CARE (2273)
Fax: 808.456.2274
Email: occmed@pearlcityurgentcare.com

OCCUPATIONAL MEDICAL SERVICES COMPANY PROFILE

Company Name:_____ **Contact Name:**_____

Company Address:_____
Street Address *City/State/Zip*

Phone Number:_____ **Fax Number:**_____

Authorization List:_____

BILLING INFORMATION

Do you want your statement printed? ❑ Yes ❑ No

How would you like your statement printed?
❑ Summary (All employees on a single page)
❑ Detailed (Each employee on a single page)
❑ Both

Would you like to include SSN on statement? ❑ Yes ❑ No

WORKERS COMPENSATION (WC) INFORMATION

Is your company self-insured? ❑ Yes ❑ No
**If no, please fill out the following information*

Name of WC Insurance Company:_____

Address:_____
Street Address *City/State/Zip*

Contact Name(s):_____

Contact Number:_____ Email:_____

Please indicate Return-To-Work availability: ❑ Modified ❑ Light ❑ No Duty Available

EMPLOYEE PAID SERVICES (EPS) INFORMATION

How would you like to pay for the services? ❑ Employee ❑ Employer ❑ Company HR ❑ Company Headquarters
** If address is same as company address above, you may leave the mailing section blank.*

Mailing Address:_____
Street Address *City/State/Zip*

Contact Name:_____ Contact Number:_____

Payments will be made attention to:_____

How would you like us to send the results (Check all that apply)? ❑ Fax ❑ Mail ❑ Email
** Emails **require** a six character password*

Mailing Address:_____
Street Address *City/State/Zip*

Email:_____ Email password:_____

Fax Number:_____ Attention to:_____

US MED URGENT CARE
Occupational Medicine Program
Dedicated to the total health of your workforce

Occupational Medicine Program
Phone: 808.456.CARE (2273)
Fax: 808.456.2274
Email: occmed@pearlcityurgentcare.com

SERVICES REQUESTED

Physicals: ❑ Yes ❑ No *Please select one of the following:* ❑ Non-DOT ❑ DOT/CDL/PUC Medical Card ❑ None
Reason for Physical: ❑ Pre-Employment ❑ Return-to-Work/Fit-for-Duty

Drug Screening: ❑ Yes ❑ No *Please select one of the following:* ❑ Non-DOT Panel 5 ❑ DOT Panel 5
❑ Instant Panel 5
❑ Other:_____

MRO Services: ❑ US Med MRO Provider ❑ Provide own MRO

Name of MRO:_____

Address of MRO:_____
Street Address *City/State/Zip*

Phone Number:_____ Fax Number:_____

Immunizations: ❑ Yes ❑ No *Please select one of the following:* ❑ Tetanus ❑ Flu ❑ TB/PPD ❑ MMR
❑ Hepatitis B Series (Series of 3 shots)
❑ Other:_____

Laboratory: ❑ Yes ❑ No *Please select one of the following:* ❑ Urinalysis ❑ CBC ❑ Zinc Protoporhin ❑Lead
❑ Heavy Metal ❑ Administration Fee

Procedures: ❑ Yes ❑ No *Please select one of the following:* ❑ EKG ❑ Pulmonary Function Test

Eye Exams: ❑ Yes ❑ No

Respirator: ❑ Yes ❑ No *Please select all that apply:* ❑ Respirator Clearance
*(*Will proceed to Respirator Physical Exam if employee fails Respirator Questionnaire)*
❑ Respirator Exam
❑ Qualitative Respirator Fit Test
*(*employee to provide resp. mask)*

Audiometric Test: ❑ Yes ❑ No
(Referred to Family Hearing Aid Center)

Alcohol Testing: ❑ Yes ❑ No *Please select one of the following:* ❑ Non-DOT ❑ DOT

Other Special Instructions:

_____

_____

_____

**Completed forms can be faxed to (808)456-2274 or emailed to occmed@pearlcityurgentcare.com*