Windsor WorkCare
OCCUPATIONAL MEDICINE

Elkhart and Middlebury Locations

Account Registration/Update

Contact Name: _____ Phone Number: _____

E-Mail: _____ Fax Number: _____

Federal Tax ID#:_____

Company Name: _____

Address: _____

Mailing Address: _____

Number of employees: _____ # of shifts: _____

Please attach cover page of Workers Compensation insurance*

Work Comp insurance carrier: _____

Policy #: _____ Address: _____

Phone #: _____ Ext: _____ Fax#:_____

Invoice(s) to be mailed to: [ ] Company [ ] Insurance Carrier

Special Instructions: EMPLOYEE MUST COME IN WITH AN AUTHORIZATION/REFERRAL WITH THE EXCEPTION OF BEING ACCOMPANIED BY AN APPROVED SUPERVISOR, IF AUTHORIZATION FORM IS INCOMPLETE WWC STAFF WILL FOLLOW UP WITH CONTACT TO INSURE PROPER FORM IS COMPLETE.

_____

_____

Company representative(s) to authorize treatment:

Name	Phone Number

Please list all personnel who will be authorized to receive drug screen results:

Name	Phone Number

Please list all personnel who will be authorized to receive work related injuries/treatment information:

Name	**Phone Number and E-Mail Address**

May we use voice mail to leave drug screen results? [ ] Yes [ ] No

How would you prefer test results reported? [ ] Phone [ ] Fax [ ] Email

Phone: _____ Fax: _____ E-mail: _____

PRE-EMPLOYMENT DRUG TESTING COMPANY PROCEDURE:

Does your company require pre-employment drug screen? [ ] Yes [ ] No | Would you like drug screens to be observed? [ ] Yes [ ] No

Rapid Drug Test: [ ] 5 Panel [ ] 7 Panel [ ] 8 Panel [ ] 9 Panel [ ] 10 Panel Other: _____

Alcohol Testing: [ ] Yes [ ] No If yes, what type? [ ] Saliva [ ] Breath | Breath if Saliva is Positive? [ ] Yes [ ] No

If employee rapid test concludes a positive, would you like the sample to be sent out to laboratory for confirmation for an additional fee? [ ] Yes [ ] No (Employee will always be giving the option to send out sample for confirmation at their expense)

Non-Regulated: Does your company require pre-employment drug screens to be sent to laboratory for results? [ ] Yes [ ] No

If yes, select test to be performed at lab? [ ] 5 Panel [ ] 7 Panel [ ] 8 Panel [ ] 9 Panel [ ] 10 Panel ____ Collection Only

Form to be used: [ ] Windsor WorkCare Form [ ] Form provided by your company

Does your company require federally regulated drug test?: [ ] Yes [ ] No

Type: [ ] NIDA/DOT [ ] Collection Only

Company Laboratory Information

Collection Lab Name: _____ Phone: _____

Account Number: _____

Would you like us to bill the company or employee? [ ] Company [ ] Employee

Please add any comments or additional information**:**

_____

_____

If employee passes drug screen does your company require a pre-placement physical? [ ] Yes [ ] No

PRE-PLACEMENT PHYSIAL COMPANY PROCEDURE:

Does your company require a pre-placement physical? [ ] Yes [ ] No

DOT Physical? [ ] Yes [ ] No

Form to be used: [ ] Windsor WorkCare Physical Form [ ] Physical form provided by your company

Minimum weight employee is required to lift? _____ pounds

Does your company require any additional testing? [ ] Yes [ ] No

[ ] Pulmonary Function Test [ ] Audiogram [ ] Respirator Approval

Are there any other test not listed that your company would like Windsor Workcare to perform or any special instructions?

_____

_____

COMPANY WORK-RELATED INJURY PROCEDURE (WCI):

Does your company require post-accident drug screen? [ ] Yes [ ] No | Would you like drug screen to be observed? [ ] Yes [ ] No

Rapid Drug Test: [ ] 5 Panel [ ] 7 Panel [ ] 8 Panel [ ] 9 Panel [ ] 10 Panel Other: _____

Alcohol Testing: [ ] Yes [ ] No If yes, what type? [ ] Saliva [ ] Breath | Breath if Saliva is Positive? [ ] Yes [ ] No

If employee rapid test concludes a positive, would you like the sample to be sent out to laboratory for confirmation for an additional fee? [ ] Yes [ ] No (employee will always be giving the option to send out sample for confirmation at their expense)

Non-Regulated: Does your company require post-accident drug screens to be sent to laboratory for results? [ ] Yes [ ] No

If yes, select test to be performed at lab? [ ] 5 Panel [ ] 7 Panel [ ] 8 Panel [ ] 9 Panel [ ] 10 Panel ____ Collection Only

Form to be used: [ ] Windsor WorkCare Form [ ] Form provided by your company

Does your company require federally regulated drug test?: [ ] Yes [ ] No

Type: [ ] NIDA/DOT [ ] Collection Only

Company Laboratory Information

Collection Lab Name: _____ Phone: _____

Account Number: _____

Please add any comments or additional information**:**

_____

_____

All Physical and Injury Reports will be mailed CONFIDENTIAL when completed to*:*

Attention to: _____ Address: _____

Signature: _____ *Date:* _____

Windsor Representative Signature: _____ *Date:* _____

Please return complete form to:

Windsor WorkCare
3100 Windsor Court
Elkhart, IN 46514

Email: Adriana@windsorworkcare.com Phone: 574-238-5132 Fax: 574-266-6888