Date:____________________________ Number of Employees:______________________

Business Name:____

Type of Business:____

Days of Operation:____Hours of Operation: _____am to ________pm

Address:____

Phone: ___________ ________________ Fax: ____________ _________________________

Most common type of work-related injury:____

Workers Compensation Carrier:____

Self Insured: ______yes ________no If yes, please provide copy of self-insured certificate

Policy #:____ Date: ______________________ thru ______________________

Address:____

Phone: ___________ _________________ Fax: ___________ ____________________________

Adjuster:_________________________________ Email: _________________________________

Special Instructions: Protocols

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Authorized Staff to send in Employee:

____

Protocols Company will be using:

Pre-Placement Physical _____________________

PPD (T.B. Skin Test) _____________________

Audiometric Test _____________________

Resp. Questions _____________________

Pulmonary Function _____________________

Fit Test (respirator) _____________________

Respiratory Exam _____________________

Basic Return to Work _____________________

Complex Return to Work + Test_____________

Lifting Test of ____lbs. _____________________

Jamar Grip Test _____________________

Visual (Color &Horiz.) ________________________

2v L/S (Lower Back X-Ray) ________________________

1v Chest X-Ray ________________________

D.O.T. Physical ________________________

D.O.T. Drug Screen ________________________

Rapid Drug Screen (neg.) ________________________

Confirmation Drug Screen ________________________

Breath Alcohol Testing ________________________

Back Evaluations ________________________

Lead ZPP Testing ________________________

Other:____