

# Company Profile

**Company Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State:  Indiana  Other: \_\_\_\_\_

Zip: \_\_\_\_\_

**Main Contact:** \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_;

FAX (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Alternate Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Alternate Contact:** \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_;

FAX (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Alternate Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Self-Pay Billing Contact-** \_\_\_\_\_

Bill to:  Same as Company Address

Other: Address \_\_\_\_\_

City: \_\_\_\_\_ State:  Indiana  Other: \_\_\_\_\_

Zip: \_\_\_\_\_

**Drug Screen Results:**  Same as Main Contact

Alt. Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Communicate by:  Phone  Fax  Mail  Other: \_\_\_\_\_

**Number of Employees:** \_\_\_\_\_

**Work Comp Billing:** Plan: \_\_\_\_\_

Group: \_\_\_\_\_ Policy: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FAX: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Bill to: Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State:  Indiana  Other: \_\_\_\_\_

Zip: \_\_\_\_\_

**Clinic Location:** (click all that apply)

- <Map location>  1) East – 1709 North Post Rd  
 2) After Hours-East – Comm. Hosp. East - 1500 North Ritter Ave  
 3) Castleton – 8177 Clearvista Parkway  
 4) After Hours-North – Comm. Hosp. North – 82<sup>nd</sup> Shadeland Ave.  
 5) Greenwood – 1664 W. Smith Valley Rd.  
 6) Carmel – 11911 N. Meridian St.  
 7) Anderson – 1030 N. Scatterfield Rd.

# Company Profile

**Drug Testing Protocol:**     Rapid     Standard  
 5-panel Non-DOT UDS     5-Panel DOT UDS     10-Panel Non-DOT UDS  
 Hair Collection only     Urine Collection only - (  DOT     Non-DOT)  
*Collection Only - Kits / Chain of Custody:*     Kept at clinic     Sent with Employee

**Laboratory:**     (S.A.M.H.S.A. Lab we utilize) South Bend Medical Foundation

Other: \_\_\_\_\_

MRO: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Post Accident:**     UDS     BAT\*

Bill to:  Company

Other: \_\_\_\_\_

**For Cause / Reasonable Suspicion:**

UDS     BAT\*

Bill to:  Company

Other: \_\_\_\_\_

**Random:**     UDS     BAT\*

Bill to:  Company

Other: \_\_\_\_\_

**Pre-Placement:**     UDS:

Bill to:  Company

Other: \_\_\_\_\_

**Worker's Comp Initial Visit:**     UDS     BAT\*

Bill to:  Company

Insurance: \_\_\_\_\_

**Post Offer Pre-Placement Exam**

**New Cert. DOT exam**

**Re-Cert DOT exam**

**Non-DOT exam**

Bill to:  Company

**Light Duty Available:**     Yes     No

\*Can be completed "Upon Request Only" if preferred.