



Worker's Compensation and/or Drugscreen Profile

Name of Company _____

Address _____

City, State & Zip _____

Phone _____

FAX _____

Contact _____

Name of Insurance Co. _____
(As it appears on insurance policy)

Work Comp Policy # _____

Address _____

City, State & Zip _____

Phone _____

Billing Address (If different from above)

Address _____

City, State & Zip _____

Phone _____

FAX _____

Contact _____

Is First Aid Available? Or do you wish that all injuries be billed to your work comp carrier? _____

Is modified duty available for injured employees? _____

Drugscreens

5 panel NON DOT drugscreen using our lab, kits,
C.O.C. (Chain of custodys) and M.R.O. services = \$58.00

Class A Drivers

DOT Drugscreen = NIDA \$58.00

Breath Alcohol Test = \$25. 00

Please specify below categories you will test:

NIDA or NON NIDA _____

Pre Employment _____

Random (DOT) _____

Post Accident _____

Reasonable suspicion _____

Please specify how you will want to receive results

Phone _____

FAX _____

Mail (Confidential) _____

The contact person or persons for drugscreen results

is _____

or _____