



COMPANY PROTOCOL INFORMATION

COMPANY INFORMATION:

Company Name: _____
Contact Name: _____ Phone: _____
Address: _____ City: _____
State: _____ Zip: _____
Email: _____ Fax: _____

BILLING INFORMATION

Company or WC Insurance Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Contact/WC Adjustor: _____ Ph: _____ Fax: _____

ADDITIONAL CONTACT(S):

Name: _____ Ph: _____ Cell: _____
Name: _____ Ph: _____ Cell: _____

ADDITIONAL TESTING:

Drug Screen: Yes No
 5 Panel Non-Nida DOT 10 Panel
Breath Alcohol Test: Yes No
 Non-DOT DOT

RETURN TO WORK FORM (RTW):

To Be Emailed: Yes No
Email Recipient: _____ Email address: _____
To Be Faxed: Yes No
Fax Recipient: _____ Fax Number: _____

TRANSCRIPTIONS:

To Be Emailed: Yes No
Email address: _____ Zip Password: mednow
To Be Faxed: Yes No
Fax Recipient: _____ Fax Number: _____

PLEASE COMPLETE AND FAX TO AMANDA JONES AT 918-806-6330