



Fill in the blanks, print and fax back this protocol to 713-802-1050

This form is vital to insure procedures are followed correctly. Should one of your employees utilize the OccuCare Clinic to report an injury or illness and you are not aware, this form will provide a protocol to follow and contacts to call. Thank you for your prompt response.

Company Profile

Date: _____

Company: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Type of Business: _____ **# Employees:** _____

1.Contact: _____ **Title:** _____ **Phone:** _____

Email: _____

2.Contact: _____ **Title:** _____ **Phone:** _____

Email: _____

Post Accident Drug Screen Required: (check) **YES** **NO**

Call Results of Drug Screen to: _____ **Phone:** _____

Call Results of Injury Treatment to: _____ **Phone:** _____

Billing Contact: _____ **Phone:** _____ **Email:** _____

Bill to: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Workers Compensation:

Send Claim to: (check) **Company** **Carrier** **W/C Alternative**

W/C Carrier: _____ **Policy #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Light Duty Available: (check) **YES** **NO**

Comments: _____
