



Employer Intake Form

Form to be completed by Employer

Contact 1 Name:	Contact 2 Name:
Contact 1 Role:	Contact 2 Role:
Contact 1 Email:	Contact 2 Email:
Contact 1 Phone:	Contact 2 Phone:
Contact 1 Cell Phone:	Contact 2 Cell Phone:
Company Information	
Company Name:	County:
Billing Address:	
Physical Address:	
Number of Employees:	
Workers Compensation Information	
Self- Insured? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Carrier Name:	Billing Address:
Phone Number:	Fax Number:
Post-Accident Drug Screen Required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Screen Panel:
TPA information (if applicable)	
TPA Name:	TPA Phone:
Billing Address:	TPA Email:
Contact Name:	Contact Email:
List of services TPA covers:	
How did you hear about FirstHealth?	
Website <input type="checkbox"/> Social Media <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	

<p><i>Clinic Services Requested: PLEASE SELECT ITEMS YOU ARE REQUESTING TO BE PERFORMED</i></p>
<p><input type="checkbox"/> Urine Drug Screen:</p> <p>Type: <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT 5, 6, 7, 8, 9, 10 (Select One) <input type="checkbox"/> Rapid 5, 6, 7, 8, 9, 10 (Select One)</p> <p>Reason: <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post Accident <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion</p> <p>Would you like online access to drug screen results? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><input type="checkbox"/> Breath Alcohol Screen (BAT):</p> <p>Type: <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT</p> <p>Reason: <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post Accident <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion</p> <p>Would you like online access to BAT results? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><input type="checkbox"/> Physicals:</p> <p>Type: <input type="checkbox"/> Pre-Placement <input type="checkbox"/> DOT <input type="checkbox"/> OSHA Surveillance <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Return to Duty</p> <p>Services: <input type="checkbox"/> Audiogram <input type="checkbox"/> PPD (TB Test)</p> <p style="padding-left: 20px;"><input type="checkbox"/> OSHA Questionnaire Review <input type="checkbox"/> Spirometry <input type="checkbox"/> Respirator Fit Test</p> <p>Would you like online access to Physical results? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><input type="checkbox"/> Immunization, Screening, Vaccinations:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Influenza Vaccination <input type="checkbox"/> Tdap (Tetanus-Diphtheria-Pertussis)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Hepatitis B Series <input type="checkbox"/> PPD (TB Test) <input type="checkbox"/> Rabies</p> <p>Would you like online access to results? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><input type="checkbox"/> Workers Compensation Evaluation/Treatment :</p> <p>Would you like online access to results? Yes <input type="checkbox"/> No <input type="checkbox"/></p>