

St. Joseph's Occupational Health/Mark Twain St. Joseph's Occ Health
Stockton, Manteca and Angels Camp
New Client Information Form

Company Name: _____

Type of Business: _____ #Employees: _____

Physical Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Main Contact Name: _____

Title: _____

Telephone #: _____ Fax #: _____

Cell #: _____ E-mail Address: _____

Workers Compensation Information

Workers Comp Carrier: _____

Address: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Policy #: _____ Effective Date: _____ Expiration Date: _____

Claim Adjuster: _____

Limited Duty Available? Yes or No

Post Injury Drug Screen Required? Yes or No

HCCL #5 panel (negative results in 24 Hrs.) \$34.00 _____

Rapid #5 panel (negative results immediately) \$45.00 _____

(Drug screens needing confirmation, results in 48 to 72 hours)

Drug screen collection only (use your company COC form) \$20.00 _____

Post Injury Breath Alcohol Required? Yes or No \$25.00 _____

Employer Services Program (ESP)

Contact Person(s): _____

Telephone #(s): _____ Fax #: _____

Cell #(s): _____ E-mail: _____

Types of ESP Services required, please check below:

Physical: DOT ____ Non DOT ____

Do you have a company form for the physical? Yes or No (If yes, additional form fee will apply.)

Drug Screen: DOT ____ Non DOT ____

HCCL #5 panel (negative results in 24 Hrs.) \$34.00 ____

Rapid #5 panel (negative results immediately) \$45.00 ____
(Drug screens needing confirmation, results in 48 to 72 hours)

Drug Screen collection only \$20.00: DOT ____ Non DOT ____ What lab? _____

Is the chain of custody (COC) kept at our clinic or sent with donor? _____

Lifting Capacity: ____ Lbs lifted: ____ Frequency: ____ (please provide job description)
Information needed: i.e. weight lifted from floor to waist, waist to shoulder or overhead.

PPD Skin Test: ____ Pulmonary Function Test: ____ Audiogram: ____ EKG: ____

X-ray: ____ What type of x-ray & how many views? _____

Hepatitis Vaccine Series: B ____ A ____ Titre (specify which one) ____
(Series of 3) (Series of 2)

Flu Immunization: ____ Health Risk Appraisals (HRA): ____ Ergonomic Assessments: ____

Interested in St. Joseph's Occupational Health: Consortium ____ Worksite Wellness ____
or On-site Nurse Program ____

Are there any special instructions you would like our clinic to follow when reporting or mailing results? If so please specify.

