WorkWell Medical Group

901 Sunset Dr., Ste 4
Hollister, CA 95023
Tel: (831) 665-6709
Fax: (831) 665-6551

809 Broadway St.
King City, CA 93930
Tel: (831) 386-7461
Fax: (831) 386-9841

831 S. Main St.
Salinas, CA 93901
Tel: (831) 422-3701
Fax: (831) 422-3751

#29b

EMPLOYER PROTOCOL

Company Name _____

Address

Street1: _____ **Street 2:** _____

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

Primary Contact Person

Name: _____ **email:** _____

Tel: _____ **Cell:** _____ **Fax:** _____

Secondary Contact Person (if applicable)

Name: _____ **email:** _____

Tel: _____ **Cell:** _____ **Fax:** _____

WORKERS COMPENSATION INSURANCE CARRIER INFORMATION

WC Insurance Carrier:	Self Insured? Yes ☐ No ☐
Claims Adjuster Name:	Telephone: ( ) --
Claims Address:	
Policy#	Effective Date: to
Telephone: ( ) --	Fax: ( ) --

Would your company like to be billed directly for First Aid injuries or should all bills be sent to your WC carrier?
Bill Company for First Aid ☐ **Bill Carrier** ☐

Does your company **require a post-injury drug test**? ☐ Yes ☐ No

Does your company accommodate Modified Work restrictions? ☐ Yes ☐ No ☐ Evaluate case by case

Contact for Work Status Reports (We prefer to send you work status reports via email)

☐ Primary Contact ☐ Secondary Contact

☐ Email ☐ Fax

Other Instructions (or people to be contacted)**:**

_____

EMPLOYER PHYSICAL EXAMINATION INSTRUCTIONS

What type of Physical Examinations do you require?

☐ Post-Offer ☐ DMV ☐ Hep B ☐ Respirator ☐ Audiogram
☐ Back Evaluations ☐ Fitness for Duty ☐ Travel ☐ Chem. Surveillance

☐ Other _____

Who should we call or fax Physical Examination results to:

Contact Person:			Telephone: ( ) --
City:	State:	Zip:	Fax: ( ) --
Email Address:			
Other Instructions:			

DRUG TESTING (If applicable)

Do you have a drug and/or alcohol testing program? ☐ Yes ☐ No

Do you need ☐ DOT or ☐ Non-DOT drug tests?

If you need non-DOT, do you need a ☐ 5-panel instant drug test or ☐ other drug test?

Will you use our testing laboratory & Medical Review Officer? ☐ Yes ☐ No

Laboratory Name (if you use your own lab.): _____

Laboratory Account#: _____

If using own lab., will ☐ employees bring COC's (chain of custodies) or

☐ we keep COC's at the clinic

If you are using your own MRO ☐

MRO Name:			Telephone: ( ) --
City:	State:	Zip:	Fax: ( ) --

OTHER INSTRUCTIONS: _____

_____

_____

Please email completed form to:

Diane Tovey at **diane@workwellmedical.com**

If you have any questions, please call Diane Tovey at (831) 422-3701 or send an email to **diane@workwellmedical.com**

Please note that if an employee is exposed to a chemical at your site we request a copy of the applicable Material Safety Data Sheet (MSDS) to accompany the patient or to be faxed to the clinic.