PHYSICIANS Immediate CARE
Phone 772-873-8155
Fax 772-873-8858
E-mail: Evan@Immedcare.com

Occupational Medicine Account

Company Name _____

Address _____

City _____ State _____Zip _____

Billing address (if different from above) _____

Contact Name _____ Phone # _____ Fax # _____

Services below are to be billed to: □ Employer □ Worker's Compensation

Please Select Requested Services:

Physicals

- □ Pre-Employment Physical Examination
- □ DOT Physical Examination
- □ Annual Physical Examination
- □ Fit for Duty Examination

Drug Screens (please note results will be sent to contact listed above unless otherwise specified)

- □ DOT/NIDA 5
- □ State of Florida Drug Free Workplace
  - □ 5 panel
  - □ 8 panel
  - □ 10 panel
- □ Rapid Result 7-Panel (Results within one hour)
- □ Collection only patient must bring supplies (cup, COC, shipping materials)

Misc Services

- □ Medical Review Officer Services
- □ Breath Alcohol
- □ Respiratory Exams/Fit Testing
- □ Audiometry
- □ Immunizations - Please specify: _____

Do you require a post accident drug screen on employees being seen under Worker's Compensation □Yes □ No
If yes, please check off test needed under **Drug screens**.
Post accident drug screens are to be billed to: □ Employer □ Worker's Compensation

Workers Compensation Insurance Company _____

Medical Billing Address _____

City _____ State _____Zip _____

Telephone # _____ Fax # _____

Additional Information _____

Fax completed form to 772-873-8858 or e-mail to Evan@Immedcare.com