Hunterdon Health

63 Church Street
Flemington, NJ 08822
Phone: 908-788-6146
Fax: 908-788-6698

OCCUPATIONAL HEALTH SERVICES CLIENT REGISTRATION FORM

I. Client Profile

Company Information	
Company Name	Address
Phone	Secure Fax
Total No. of Employees	Days/Hours of Operation
Type of Business	New Client ☐ Updated Client Information ☐
Contact Information	
Primary (Designated Employer Representative)	Secondary
Title	Title
Phone	Phone
Fax	Fax
Email	Email
Workers Compensation Insurance Information	
W/C Carrier/Third Party Administrator	Adjuster/Contact Name
Address	Phone
Fax	Email
Policy No.	
Company Billing Information (for employer paid services)	
Billing Address	
Contact	
Special Instructions	
Recipient of Results/Reports	
Preferred Method of Receiving Results/Reports ☐ Email ☐ Fax ☐ Telephone ☐ Mail	
Specify Documentation Requirements:	
Additional Instructions:	
Please Answer the Following:	
Do you permit Modified Return to Duty? ◯ Yes ◯ No	

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II. Requested Services

Work Related Injury Care:	**Physical Examination:**
Work Related Injury Treatment Post-Accident Drug Screen Required ◯ Yes ◯ No	☐ Pre-Employment ☐ Return to Work/Fit for Duty ☐ DOT ☐ Positive PPD ☐ Other _____ _____ _____
Drug Screening: ◯ DOT ◯ Non-DOT ☐ Post-Accident ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion Rapid Test: ☐ 9 Panel (non-THC) ☐ 10 Panel Non-DOT Lab Test : ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 9 Panel (+Narcotics) ☐ 9 Panel (non-THC+Narcotics) ☐ Other_____ DOT Agency: ☐ FMCSA ☐ FTA ☐ PHMSA ☐ FAA ☐ FRA ☐ USCG ☐ Other: _____ ☐ Collection Only	**Immunizations:** ☐ TB Skin Test (2 Step) ☐ TSpot TB (Blood Test) ☐ Tdap ☐ MMR ☐ Influenzas (Seasonal) ☐ Hep B ☐ Titers (Specify below) _____ _____ _____
Breath Alcohol Testing: ◯ DOT ◯ Non-DOT ☐ Post-Accident ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion	**Other Services:** ☐ Audiogram ☐ Vision Test ☐ Spirometry ☐ Respiratory Evaluation ☐ Respiratory Fit Test ☐ Other _____ ☐ Other _____
Additional Services:	

III. Client Authorization

AUTHORIZED BY: We (Employer) are authorizing Hunterdon Health Occupational Health Services to provide work comp treatment and/or occupational health services to employees. By doing so, we acknowledge that we are responsible for payment of any and all services in the event a claim is not filed or denied.

Signature: _____

Name: _____ Title: _____ Date: _____

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