New Company Data Collection Form

Patient Name:_____ Date of Service:_____ Company Name:_____

Company Phone :_____ RMG Staff Member Collecting Data:_____

Business Name:_____

Main Contact:_____ Main Phone:_____

Direct Phone:_____ Fax:_____ E-Mail:_____

Address:_____

City:_____ State:_____ Zip:_____ Is this also your billing address? YES / NO

BILLING ADDRESS (*Only if different from company address)(This could be WC billing or if they have a PO Box for bills)*

Business Name:_____

Billing Contact:_____ Main Phone:_____

Direct Phone:_____ Fax:_____ E-Mail:_____

Address:_____

City:_____ State:_____ Zip:_____

SERVICES AUTHORIZED TODAY:

Substance Testing

__ DOT __ Non DOT __ Collection Only

__ Urine __ Hair __ BAT

__ 5 Panel * __ 5 Panel

__ 7 Panel __ 5 Panel Exp.

__ 9 Panel

__ 10 Panel*

__ Rapid (starred panels only)

Exam Services

__ DOT Physical __ TB

__ Basic Physical __ PFT

__ Annual Work Exam __ Titmus Vision

__ Work Injury

__ Fit for Duty/Return to Work

If Substance Testing is Authorized ***Circle only one method for receiving results***

Contact(s) for Results: Name:_____ Fax/Phone/Portal:_____

Name:_____ Fax/Phone/ Portal:_____

Name:_____ Fax/Phone/ Portal:_____

Name of Contact Authorizing Services:_____ Title:_____