



Occupational Medicine of Columbus

New Company Information Sheet

Date _____

Company _____

Company Address _____

Contact Person _____ Email Address _____

Phone Number _____ ext. _____ Fax Number _____

Secondary Contact Person _____ Email Address _____

Phone Number _____ ext. _____ Fax Number _____

Insurance Company _____

Insurance Address _____

Insurance Phone Number _____ ext. _____ Insurance Fax Number _____

Circle all that apply

Workers' Compensation	General/New Hire Physical	Fit for Duty/Return to Work Physical
DOT Physical	DOT or NON-DOT Drug Screen	Drug Screen Collection
Lab work	Instant Drug Testing 5 panel, 8 panel, or 10 panel	
Immunizations	Breath Alcohol Testing	Saliva Alcohol Testing

Circle all Drug Testing that apply

Pre-employment Random Post-Accident (Injury Treatment) Post-Accident (NO Injury)

PLEASE FAX BACK TO 706-221-1605