New Client Onboarding Information Sheet

Please email completed form to esform@ccmdcenters.com

Company Name:

Address:

Billing Address if Different:

Number of Employees:

Primary Contact for Injuries:

Telephone Number:

Fax:

E-mail Address:

Name of Workers' Comp Carrier:

Workers' Comp Address:

Policy #:
Effective Date:

Broker:

Contact:

Telephone #:

Third Party Administrator:
Address:

Phone Number:
Contact:

Please see page 2 for services requesting

Physicals		
Description	**Include Service**	**Employer/Employee/TPA Paid**
DOT Physical	☐	
Employment Physical	☐	
Drug & Alcohol Testing		
Description	**Include Service**	**Employer/Employee/TPA Paid**
Breath Alcohol Test	☐	
DOT Drug Collection	☐	
DOT Drug with MRO	☐	
Non-DOT Drug Collection	☐	
Non-DOT Drug with MRO	☐	
Instant Drug Test (NH Only)	☐	
Lab Testing		
Description	**Include Service**	**Employer/Employee/TPA Paid**
Hepatitis B Surface AB (Includes Venipuncture)	☐	
Lead with ZPP Test (Includes Venipuncture)	☐	
TB Skin Test	☐	
Quantiferon Gold	☐	
Vaccinations		
Description	**Include Service**	**Employer/Employee/TPA Paid**
Hepatitis B	☐	
Tetanus	☐	
Tetanus/Diphtheria/Pertussis (TDAP)	☐	
Influenza	☐	
X-ray		
Description	**Include Service**	**Employer/Employee/TPA Paid**
Chest X-Ray	☐	
Chest X-Ray with B Read	☐	
Miscellaneous		
Description	**Include Service**	**Employer/Employee/TPA Paid**
Work Related Injury/Illness	☐	
Vision	☐	

Please print, sign and date:

_____ _____

Print Title

_____ _____

Sign Date