

# PACIFIC MEDICAL CLINIC

## EMPLOYER PROFILE

**EMPLOYER**

**NAME:**

ADDRESS:

CITY,

STATE,

ZIP:

PHONE: ( ) \_\_\_\_\_

CONTACT

PERSON:

FAX: ( ) \_\_\_\_\_

ALTERNATE

CONTACT:

SIC CODE: \_\_\_\_\_ # EMPLOYEES \_\_\_\_\_ # OF SHIFTS/HRS: (D) \_\_\_\_\_ - \_\_\_\_\_ (E) \_\_\_\_\_ - \_\_\_\_\_ (N) \_\_\_\_\_ -

AND/OR

NATURE OF BUSINESS (e.g. food manufacturing, building construction, retail department store):

**WORKERS**

**COMP**

**INSURANCE**

**CARRIER:**

ADDRESS

(OR

P.O.

BOX):

CITY,

STATE,

ZIP:

PHONE: ( ) \_\_\_\_\_ POLICY #: \_\_\_\_\_ EXPIRES: \_\_\_\_\_ /

MODIFIED WORK AVAILABLE: ( ) YES ( ) NO

TYPE OF BILLING (circle one): 1. BILL EMPLOYER/SELF-INSURED 2. ALWAYS BILL INSURANCE DIRECTLY

**BILLING**

**COMMENTS:**

**POST-OFFER PHYSICALS REQUIRED:**    (    ) YES    (    ) NO

**EMPLOYEE DRUG SCREEN:**(If applicable)    (    ) PANEL 7 (without alcohol)    (    ) PANEL 10 (with alcohol)

(    ) DOT FEDERAL DRUG SCREEN    (    ) COLLECTION ONLY    (    ) BREATH ALCOHOL TEST

**SPECIAL**

**INSTRUCTIONS:**

\_\_\_\_\_  
Employer/Representative Signature

\_\_\_\_\_  
Title/Position

\_\_\_\_\_  
Date

Note: Information provided on this form is considered confidential in nature and will be used only for the administration of occupational medical services between **Pacific Medical Clinic** and the above named Company/Employer. This information will not be released to any outside agencies under any circumstances without expressed permission from the Employer.

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