

WRI New Account Set-Up

Company Name: _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Company Contact: _____ **Phone Number:** _____

After Hours Contact: _____ **Phone Number:** _____

E-mail Address: _____ **Fax:** _____

Does your company offer Healthcare: Yes: _____ No

Billing: Worker's Comp Ins. <input type="checkbox"/> Yes <input type="checkbox"/> Yes, but send the bills to my company <input type="checkbox"/> No Workers Comp. Insurance: _____ Are you in their network? <input type="checkbox"/> First Health <input type="checkbox"/> Carvel <input type="checkbox"/> Southwest Medical Provider Billing Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____ Fax Number: _____
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Services and Contacts

Post Accident Drug Testing

Required Only when requested

Type of Drug Test: DOT
 5 Panel
 10 Panel
 Rapid (5 Panel)

Please Check which results contacts are authorized to receive

Post Accident Breath Alcohol

Required Only when requested

Company Contact: _____ **Phone Number:** _____

E-Mail: : _____ **Fax :** _____

Drug Test Results Breath Alcohol Results Work Status Reports Physical Results Other

Company Contact: _____ **Phone Number:** _____

E-Mail: : _____ **Fax :** _____

Drug Test Results Breath Alcohol Results Work Status Reports Physical Results Other