Employer Profile Form

New Company Information & Updates

To establish or update an account with Texas MedClinic, follow the instructions below:

- Fill out the Employer Profile form
- Once completed please email to *businessdevelopment@texasmedclinic.com*
- Allow 1-2 business days for processing
- A Client Service Specialist will contact you once the request has been completed.

Thank you for choosing Texas MedClinic
to handle your Occupational Healthcare needs.

Texas MedClinic® URGENT CARE

EMPLOYER PROFILE FORM

Date Completed : _______________

Completed by: ___________________

COMPANY INFORMATION

☐ New Account ☐ Update

Company Name:______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: __________

Phone: ______________________ Fax : ______________________

Email: ______________________________

Company Industry/Trade: ______________ Number of Employees: ______________

☐ **Company has multiple locations (Please provide a list of locations)**

COMPANY CONTACTS

Name: ____________________Title:__________

Phone: ______________________Ext: ______

Cell: ______________________________

Fax: ______________________________

Email: ______________________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

Name: ____________________Title:__________

Phone: ______________________Ext: ______

Cell: ______________________________

Fax: ______________________________

Email: ______________________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

Name: ____________________Title:__________

Phone: ______________________Ext: ______

Cell: ______________________________

Fax: ______________________________

Email: ______________________________

Portal Authorized User: ☐ **Yes** ☐ **No**

☐ Work Related Documents ☐ Occupational Documents

Treatment Authorization

☐ Work Related Injuries ☐ Occupational ☐ After Hours Contact

Updates— Remove Contact Name (s):

____

____

____

Texas MedClinic® URGENT CARE

OCCUPATIONAL SERVICES

Company Name: _____

Date: _____

Completed by: _____

OCCUPATIONAL SERVICES BILLING:

Occupational Billing Contact:	Billing Address (if different than physical address):
Name: _____	Address: _____
Phone: _____ Ext: _____	City/State: _____
Email: _____	Zip: _____

Consortium or third party administrator (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

☐ **I do not use a consortium or third party administrator, bill company.**

SERVICES:

Treatment Authorization Required : ☐ Yes ☐ No

Physicals

- ☐ Post Offer Physical (Job Description Required)
- ☐ DOT Physical
- ☐ Respirator Physical
- ☐ Hazardous Waste Physical
- ☐ Asbestos Physical
- ☐ Silica Dust Exam 1 day
  (Includes: T-Spot blood test, Chest X-Ray, PFT & Physical)
- ☐ Silica Dust Exam 2 day
  (Includes: TB Skin Test, Chest X-Ray, PFT & Physical)

All Physicals listed above will be performed using Texas MedClinic's forms unless otherwise indicated

☐ Company specific forms— Attach copy of forms
(A Business Development Rep will contact you to provide information on pricing for company specific forms)

Ancillary

- ☐ Hearing Test
- ☐ Vision
- ☐ PFT/Spirometry
- ☐ Respirator Fit Test

Immunizations

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR
- ☐ Varicella
- ☐ Tdap
- ☐ Flu Shot
- ☐ Other:_____

Titers

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR
- ☐ Varicella
- ☐ Other:_____

TB Testing*

- ☐ TB Skin Test
- ☐ T-Spot Blood Test
- ☐ Chest X-Ray

*Additional TB testing will be required for positive results which will include an alternate TB test. If an alternate test also comes back positive the next step will include a chest x-ray and physician evaluation.
Please select an option below regarding additional TB testing.

☐ **Treatment authorization is required if additional TB testing is needed**

☐ **All services are authorized if additional TB testing is needed**

NON-DOT Drug Testing

Pre-Employment	Random	For Cause/Reasonable Suspicion
☐ Hair Drug Test	☐ Hair Drug Test	☐ Hair Follicle
☐ Non-DOT 5 Panel	☐ Non-DOT 5 Panel	☐ Non-DOT 5 Panel
☐ Non-DOT 10 Panel	☐ Non-DOT 10 Panel	☐ Non-DOT 10 Panel
☐ Rapid 5 Panel	☐ Rapid 5 Panel	☐ Rapid 5 Panel
☐ Rapid 10 Panel	☐ Rapid 10 Panel	☐ Rapid 10 Panel
	☐ Breath Alcohol	☐ Breath Alcohol

DOT Drug Testing

☐ DOT Drug Test
☐ DOT Breath Alcohol Test

DOT Testing Agency		DOT Testing Authority
☐ FMCSA	☐ FTA	☐ DOT
☐ FAA	☐ PHMSA	☐ HHS
☐ FRA	☐ USCG	☐ NRC

Reasons for DOT Drug Testing (Check all that apply)

☐ Pre-Employment	☐ For Cause
☐ Random	☐ Reasonable Suspicion
☐ Return to Duty	☐ Other

Texas MedClinic® URGENT CARE

WORKERS COMP SERVICES

Company Name: _____

Date: _____

Completed by: _____

WORKERS' COMPENSATION BILLING:

Workers Comp Billing Contact:

Name: _____

Phone: _____ Ext: _____

Email: _____

☐ **Non- Subscriber** (Do not have Workers Comp insurance)

Address: _____

City/State: _____

Zip: _____

Workers Comp Insurance (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Are you in a Network? ☐ Yes ☐ No Please indicate name of Network: _____

WORKERS COMP INFORMATION

Does your company offer Modified Duty for injured workers?	☐ **Yes** ☐ **No**
Will a supervisor / manager bring in injured workers?	☐ **Yes** ☐ **No**
Are there any company specific forms that need to be completed for work related injuries? ***(If answer is yes, please provide a copy for review)***	☐ **Yes** ☐ **No**
Does your company complete an OSHA 300 log?	☐ **Yes** ☐ **No**
Does your company use a Third Party Administrator (TPA) or Professional Employer Organization (PEO) to manage work related injuries?	☐ **Yes** ☐ **No**

- **If answer is yes to previous question, please provide TPA/PEO information below:**

TPA/PEO (if applicable):

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____ Email: _____

POST ACCIDENT DRUG & ALCOHOL TESTING SERVICES

Drug Tests			Breath Alcohol Tests
☐ 5 Panel Non-DOT	☐ 5 Panel Rapid	☐ Hair Follicle	☐ DOT BAT
☐ 10 Panel Non-DOT	☐ 10 Panel Rapid	☐ DOT	☐ Non– DOT BAT

☐ **Drug testing is required for all injuries**

☐ **Breath Alcohol testing is required for all injuries**

☐ **Drug testing when requested only**

☐ **Breath Alcohol when requested only**