



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.**

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

Main Contact & Employer Portal Administrator

Name: _____ Title: _____

Phone: _____ Ext: _____

Cell: _____

Fax: _____

Email: _____

Cowork Health Employer Portal

*For new portal account users: The main contact / portal administrator will receive an invitation email from Cowork Health to setup our account. **The invitation email to create your portal account is valid for 72 hours from the time that it is sent. If the account is not set up within that timeframe, the invitation link will expire, and a new one will need to be issued upon request.** All reporting and billing documents will be accessible through the portal. Cowork also allows clients to send messages and share files directly with Texas MedClinic client services team. It is important that you set up your portal account without delay to ensure timely access to all necessary information and updates.*

If at any time you are experiencing issues, do not hesitate to contact us. Phone: 210.403.4214 / Email: businessdevelopment@texasmedclinic.com

Additional Contacts for Treatment Authorization / Verification

Name: _____ Title: _____

Phone: _____ Ext: _____

Cell: _____

Email: _____

Authorize Services for: Work Related Injuries Occupational

After Hours Contact: Work Related Injuries Occupational

Name: _____ Title: _____

Phone: _____ Ext: _____

Cell: _____

Email: _____

Authorize Services for: Work Related Injuries Occupational

After Hours Contact: Work Related Injuries Occupational

Updates— Remove Contact Name (s):

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 For Employer Paid Services (EPS) Required : Yes No

<p>Physicals</p> <p><input type="checkbox"/> Post Offer Physical (Job Description Required)</p> <p><input type="checkbox"/> DOT Physical</p> <p><input type="checkbox"/> Respirator Physical</p> <p><input type="checkbox"/> Hazardous Waste Physical</p> <p><input type="checkbox"/> Asbestos Physical</p> <p><input type="checkbox"/> Silica Dust Exam 1 day (Includes: T-Spot blood test, Chest X-Ray, PFT & Physical)</p> <p><input type="checkbox"/> Silica Dust Exam 2 day (Includes: TB Skin Test, Chest X-Ray, PFT & Physical)</p> <p style="background-color: #cccccc; text-align: center;">All Physicals listed above will be performed using Texas MedClinic's forms unless otherwise indicated</p> <p><input type="checkbox"/> Company specific forms— Attach copy of forms (A Business Development Rep will contact you to provide information on pricing for company specific forms)</p>	<table border="1"> <tr> <th style="background-color: #cccccc;">Ancillary</th> <th style="background-color: #cccccc;">Immunizations</th> <th style="background-color: #cccccc;">Titers</th> </tr> <tr> <td> <input type="checkbox"/> Hearing Test <input type="checkbox"/> Vision <input type="checkbox"/> PFT/Spirometry <input type="checkbox"/> Respirator Fit Test </td> <td> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Tdap <input type="checkbox"/> Flu Shot <input type="checkbox"/> Other: _____ </td> <td> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Other: _____ </td> </tr> </table>	Ancillary	Immunizations	Titers	<input type="checkbox"/> Hearing Test <input type="checkbox"/> Vision <input type="checkbox"/> PFT/Spirometry <input type="checkbox"/> Respirator Fit Test	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Tdap <input type="checkbox"/> Flu Shot <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Other: _____
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<p>TB Testing*</p> <p><input type="checkbox"/> TB Skin Test</p> <p><input type="checkbox"/> TB Blood Test</p> <p style="font-size: small;">*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 TB clearance physician evaluation. Please select an option below regarding additional TB testing.</p> <p><input checked="" type="radio"/> Treatment authorization is required if additional TB testing is needed</p> <p><input type="radio"/> All services are authorized if additional TB testing is needed</p>							

NON-DOT Drug Testing			DOT Drug Testing					
<p>Pre-Employment</p> <p><input type="checkbox"/> Hair Drug Test</p> <p><input type="checkbox"/> Non-DOT 5 Panel</p> <p><input type="checkbox"/> Non-DOT 10 Panel</p> <p><input type="checkbox"/> Rapid 5 Panel</p> <p><input type="checkbox"/> Rapid 10 Panel</p>	<p>Random</p> <p><input type="checkbox"/> Hair Drug Test</p> <p><input type="checkbox"/> Non-DOT 5 Panel</p> <p><input type="checkbox"/> Non-DOT 10 Panel</p> <p><input type="checkbox"/> Rapid 5 Panel</p> <p><input type="checkbox"/> Rapid 10 Panel</p> <p><input type="checkbox"/> Breath Alcohol</p>	<p>For Cause/Reasonable Suspicion</p> <p><input type="checkbox"/> Hair Follicle</p> <p><input type="checkbox"/> Non-DOT 5 Panel</p> <p><input type="checkbox"/> Non-DOT 10 Panel</p> <p><input type="checkbox"/> Rapid 5 Panel</p> <p><input type="checkbox"/> Rapid 10 Panel</p> <p><input type="checkbox"/> Breath Alcohol</p>	<p><input type="checkbox"/> DOT Drug Test</p> <p><input type="checkbox"/> DOT Breath Alcohol Test</p> <table border="1" style="width: 100%;"> <tr> <th style="background-color: #cccccc;">DOT Testing Agency</th> <th style="background-color: #cccccc;">DOT Testing Authority</th> </tr> <tr> <td> <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA </td> <td> <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <input type="checkbox"/> DOT <input type="checkbox"/> HHS <input type="checkbox"/> NRC </td> </tr> </table> <p style="background-color: #cccccc; text-align: center; font-size: small;">Reasons for DOT Drug Testing (Check all that apply)</p> <p><input type="checkbox"/> Pre-Employment</p> <p><input type="checkbox"/> Random</p> <p><input type="checkbox"/> Return to Duty</p> <p><input type="checkbox"/> For Cause</p> <p><input type="checkbox"/> Reasonable Suspicion</p> <p><input type="checkbox"/> Other</p>		DOT Testing Agency	DOT Testing Authority	<input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA	<input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <input type="checkbox"/> DOT <input type="checkbox"/> HHS <input type="checkbox"/> NRC
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Company Name: _____

Date: _____

Completed by: _____

WORKERS' COMPENSATION BILLING:

Workers Comp Billing Contact:

Non- Subscriber (Do not have Workers Comp insurance)

Name: _____

Address: _____

Phone: _____ Ext: _____

City/State: _____

Email: _____

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	
<input type="checkbox"/> 5 Panel Non-DOT	<input type="checkbox"/> 5 Panel Rapid	<input type="checkbox"/> Hair Follicle	<input type="checkbox"/> DOT BAT	
<input type="checkbox"/> 10 Panel Non-DOT	<input type="checkbox"/> 10 Panel Rapid	<input type="checkbox"/> DOT	<input type="checkbox"/> Non- DOT BAT	

Drug testing is required for all injuries

Drug testing when requested only

Breath Alcohol testing is required for all injuries

Breath Alcohol when requested only