Occupational Health Enrollment Form

Account Information

New Enrollment ☐ Renewal ☐ Revision ☐ Number of Employees

Account/Company Name:	Phone Number:
Legal Entity Name:	Fax Number: Secure ☐
Physical Address:	
Billing Address:	
Parent Company: Yes ☐ No ☐ If yes, name of Parent Company:	

Group Health Insurance Information

Self-Insured ☐ Fully-Insured ☐ Level Funded ☐	Renewal Date:
Broker Agency/Broker:	Carrier:
Do you currently have any of the following programs?	Wellness ☐ Telemedicine ☐ Digital Medicine ☐

Contact Information

Primary: Name & Title	Phone:	Authorize ☐ Results ☐
	Email:	
Secondary: Name & Title	Phone:	Authorize ☐ Results ☐
	Email:	
Additional: Name & Title	Phone:	Authorize ☐ Results ☐
	Email:	
Billing: Name & Title	Phone:	Authorize ☐ Results ☐
	Email:	

Worker's Compensation Insurance Information

Self-Insured: Yes ☐ No ☐	If yes, Claims Adminstrator:
WC Carrier:	Carrier Address:
Send WC Claims to: WC Carrier ☐ Employer ☐ Case by Case ☐	

Work Related Injury Information

OSHA Sensitivity ☐

Person to receive work status:			
How to receive work status?	Email:		Phone:
Modified Duty:	Yes ☐	No ☐	Case by Case ☐
Substance Abuse Testing Required:	Yes ☐	No ☐	Case by Case ☐
Additional Comments:			

Employer Testing Information

Pre-Placement Services

Annual Physicals Required? Yes ☐ No ☐

Physical:

	DOT	☐	Non-DOT	☐	USCG	☐	Other ☐
Own Form:	Yes	☐	No	☐			

Substance Abuse:

Drug Screen:	Yes	☐	No	☐			
	DOT	☐	Non-DOT	☐	Rapid	☐	Hair ☐
			5 panel	☐	5 panel	☐	Oral fluids ☐
			10 panel	☐	10 panel	☐	
Own Lab Account:	Yes	☐	No	☐	Lab:_____		Account # _____
Breath Alcohol:	Yes	☐	No	☐	Saliva	☐	

Ancillary Services:

Audiogram	☐	IPCS Evaluation	☐
Hearing Conservation Program	☐	Weight Verification	☐
Pulmonary Function Test	☐	Required for Respirator Fit Test	
OSHA Questionnaire	☐	Required for PFTs and Respirator Fit Test	
Respirator Fit Test	☐	Mask Make & Model:_____	
Labs	☐	Please list: _____	
X-rays	☐	Please list: _____	
Agilities	☐	Provide requirements	
Immunizations	☐	Please list: _____	
Lift Test	☐	Pounds:_____	
Nerve Conduction	☐	**Comments**:_____	
Strength & Flex Evaluation	☐	_____	
Color Vision	☐	_____	
Musculoskeletal Evaluation	☐		
Hemoccult Rapid	☐		

Specialty Physicals:

Asbestos Physical	☐
Benzene Physical	☐
Silica Physical	☐

Post Accident Substance Abuse Testing

Required for:	All injuries	☐					
Drug Screen:	DOT	☐	Non-DOT	☐	Rapid	☐	Hair ☐
			5 panel	☐	5 panel	☐	Oral fluids ☐
			10 panel	☐	10 panel	☐	
Breath Alcohol:	Yes ☐	No ☐			Saliva	☐	

Designated Employee Rep:

Name: _____ **Email:** _____

_____ _____

Signature Date

_____ _____

Printed Name Title

Email completed form to: OchsnerEmployerConnect@Ochsner.org