Fax: (302) 454-7733
15 Omega Drive • Building K
Newark, Delaware 19713
(302) 368-5100

Omega Medical Center
Your Occupational Health Resource

CLIENT PROFILE

Date _____

COMPANY INFORMATION

Company Name _____

Street Address _____

City _____ State _____ Zip _____

General Phone # _____ Fax # _____

Number of Employees _____ Number of Shifts _____

Principal Business Description _____

_____

_____

Potential Hazards, Exposures (e.g. toxins, noise, etc...) Please Attach MSDS

_____

_____

Name of Company Doctor and/or Medical Person on Site _____

Medical Department # _____

BILLING INFORMATION

Worker's Compensation Insurance: Self _____ Co. _____

Verification to Bill Worker's Compensation Insurance Direct: Yes _____ No: _____

Worker's Compensation Billing Name and Address: _____

_____

City _____ State _____ Zip _____

Attention: _____ Phone # (_____) _____

PLEASE LIST THE FOLLOWING COMPANY PERSONNEL RESPONSIBLE FOR:

Primary Contact Title Phone

_____

Secondary Company Contact

_____

Safety _____

Injury Reporting 1. _____

2. _____

Drug Screen Reports 1. _____

2. _____

Filing Worker's Compensation _____

Company Billing _____

Physical Exam Reports _____

Scheduling Physical _____

IMPORTANT: Please Notify **Omega Medical Center** of any changes in above personnel.

INSTRUCTIONS FOR INJURY MANAGEMENT

Light Duty Available ☐ Yes ☐ No If yes, explain_____

_____

_____

Special Requests for Referrals/Physicians, etc_____

_____

_____

INSTRUCTIONS FOR PHYSICAL EXAMINATION MANAGEMENT

Pre-Placement_____

_____

Annual _____

_____

Periodic for Occupational Disease Exposures_____

_____

Executive _____

_____

Return-to-Work_____

_____

Exit_____

_____

Other _____

_____

DRUG AND ALCOHOL SCREENING

N.I.D.A. Drug Screen _____

DuPont Drug Screen _____

Regular Drug Screen_____

(all chain of custody)

Drug Screen Collections (only) _____

Blood Alcohol_____

EMPLOYER'S AUTHORIZATION FOR TREATMENT

Omega Medical Center is hereby authorized and directed to treat employees sent to Omega Medical Center from the employer. Reasonable medical care is hereby authorized to address symptoms and complaints presented to Omega from the patient and the employer hereby acknowledges its responsibility for any and all medical charges generated through treatment by Omega.

Authorized Employer's Signature_____