



# EMPLOYER PROFILE

<b>Facility</b>	<b>Chino</b> <input type="checkbox"/>	<b>Corona</b> <input type="checkbox"/>
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Name of Company:			
Address:		City:	State: Zip:
Telephone: (    )		Fax #: (    )	
Type of Business:		No. of Employees:	
Web Site:		Email:	
Contact Person (Days)		Title:	Telephone: (    )
Contact Person (Nights)		Title:	Telephone: (    )

**COMPANY REQUIREMENTS**

Employment Physical:

Annual Physical:

Risk Screening:

**MODIFIED WORK PLAN:** Yes  No  If yes, indicate plan:

**FIRST AID PLAN:**

**WORKERS COMPENSATION**

We will receive authorization by: Written Form  Telephone

If by telephone, authorized referrers:

Are injured workers allowed to return to light duty? Yes: No:

Contact person to discuss options: Telephone (    )

Are you self-insured? Yes  No  If self insured, are you self-administered? Yes  No

Carrier / Administrator Name: POLICY #

Mailing Address:

City: State: Zip Code:

Contact Person: Telephone: (    )

**SEND BILLING DIRECTLY TO:** Employer  Carrier / Administrator

Any Specific billing directions:

Specialist(s) approved by company for referral:

Pre-Employment Physical With: (Check Box)			COMMENTS
<input type="checkbox"/>	Vision	<input type="checkbox"/>	Chest X-Ray
<input type="checkbox"/>	Urine	<input type="checkbox"/>	Drug Screen (Mark One) Nidia: Non-Nidia:
<input type="checkbox"/>	Pulmonary	<input type="checkbox"/>	Collection & Handling Only
<input type="checkbox"/>	Audiometry	<input type="checkbox"/>	Lab
<input type="checkbox"/>	Spirometry	<input type="checkbox"/>	T.B. Test
<input type="checkbox"/>	EKG	<input type="checkbox"/>	Other

Prepared By:	Title:	Date:
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