PIVOT
OCCUPATIONAL HEALTH

ENROLLMENT FORM

Company: _____ Date: _____

Address: _____

Number of Employees: _____ Pivot Clinic Location(s) Utilizing: _____

RESULTING	Contact Name	Email	Phone	Fax
Injuries				
Physicals				
Drug Testing				
**All results to be emailed unless otherwise stated— CHECK BOX TO AGREE* ☐				

BILLING—MEDICAL TESTING SERVICES

Billing Address: _____
Contact Name: _____ Number: _____
Billing Email: _____

BILLING—WORKER COMPENSATION INSURANCE

Carrier: _____ Phone #: _____
Policy #: _____ Effective Dates: _____

Please select all services you are interested in PIVOT providing:

☐ **Work Injury Treatment** ☐ *Check if post-accident drug test mandatory—Drug Test Type:* _____

Physical Examinations:

☐ Pre-employment ☐ DOT ☐ Annual/Exit ☐ Return to Work ☐ Fitness for Duty ☐ Asbestos
☐ Respirator Clearance ☐ Respirator Questionnaire Review Only ☐ Hazmat ☐ Other_____

Substance Abuse Testing:

☐ DOT Drug Screen (please circle which agency applies: FMCSA FAA FTA FRA PHMSA USCG)
☐ 10 Panel ☐ 5 Panel ☐ Rapid 10 Panel ☐ Rapid 5 Panel ☐ Hair Test
☐ Breath Alcohol ☐ Alcohol Saliva ☐ DOT Random Program ☐ NON-DOT Random Program
**Check reason for drug test(s): ☐ Pre-employment ☐ Post-accident ☐ Random ☐ Reasonable Cause*
☐ Collection Only—TPA/Lab Name: _____ Account #: _____

Other Services

☐ Respirator Fit Test (Model #: _____ Circle test: Qualitative/Quantitative) ☐ Pulmonary Function Test
☐ Audiogram ☐ PPD ☐ EKG ☐ Chest X-ray ☐ Lift Test ☐ Back Evaluation ☐ Physical Ability Test
☐ Vaccinations: _____ ☐ Blood Tests:_____
☐ Other:_____

Specific Instructions/Comments: _____
_____

Acknowledgment: I have verified the above information is correct. Fax numbers, email addresses, and mailing addresses are unique to their recipients and not accessible to the public or unauthorized users. On behalf of my organization, I agree to the billing terms and conditions.

_____ _____
Employer Signature ***Date***