SUNRISE healthcare centers

## Work Related Injury Information

**Company Name** _____
**Local Address:** _____**City:** _____ **State:** _____ **Zip:** _____

**Mailing Address:** _____**City:** _____ **State:** _____ **Zip:** _____

**1) Contact Names:** _____ **Phone:** _____
**Fax:** _____ **E-Mail:** _____

**2) Contact Names:** _____ **Phone:** _____
**Fax:** _____ **E-Mail:** _____

**Number of employees:** **Day shift**_____ **Swing shift**_____ **Graveyard shift**_____

**Corporate Office Address:** _____**City:** _____ **State:** _____ **Zip:** _____

**1) Contact Names** _____ **Phone:** _____
**Fax:** _____**E-Mail:** _____

**2) Contact Names** _____ **Phone:** _____
**Fax:** _____**E-Mail:** _____

**Work Comp Carrier:**_____ **Policy #:** _____
**Address:** _____**City:** _____ **State:** _____ **Zip:** _____

| | | | | | |
|---|---|---|---|---|---|
| **Drug Screen for New Injuries** | **Yes** | **No** | **Follow-up before or after work** | **Yes** | **No** |
| **Breath alcohol test (B.A.T.)** | **Yes** | **No** | **Phone call after treatment** | **Yes** | **No** |

**Employer Status:** **Fax** **Email** **E-fax**

**Special Instructions:** _____
_____.

## Post offer exam information

**1) Contact Names:** _____ **Phone:** _____
**Fax:** _____ **E-Mail:** _____

**2) Contact Names:** _____ **Phone:** _____
**Fax:** _____ **E-Mail:** _____

**Drug Screen:** **Rapid** **D.O.T.** **Non-D.O.T.** **Clinic account** **Company account**

**Other Exams:** _____ _____ _____ _____ _____ _____ _____

**Special Instructions:** _____
_____