Update Account Information

WorkFitMedical
Occupational Health Services

Date: ___/___/_____

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

GENERAL CONTACT INFORMATION (Only necessary to complete if changing)

Main Contact: _____
Email Address _____ Phone: _____ Fax: _____

Authorization Required? ☐ Yes ☐ No
How would you prefer to receive your results? (Check One): ☐ Mail ☐ E-Mail ☐ Fax

Designated Employer Representative (DER*): _____
Email Address _____ Phone: _____ Fax: _____

Is this an additional contact or replacement? ☐ Addition ☐ Replacement
***The DER will Receive Company Results for Drug Testing ***

BILLING CONTACT INFORMATION (Only necessary to complete if changing)

A/P Contact: _____
Address: _____
City _____ State: _____ Zip: _____
Email Address _____ Phone: _____ Fax: _____

Change to standard services? ☐ Yes ☐ No
Requested Change: _____

W/C Insurance Carrier: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Company Specific Notes/Protocols:

_____
_____
_____
_____
_____
_____
_____
_____

Change in Substance Abuse Protocol?

☐ House Lab ***OR*** ☐ Collect Only
☐ DOT ***OR*** ☐ Non DOT
☐ Rapid ***OR*** ☐ Lab send out
☐ With THC ***OR*** ☐ Without THC

Panel:_____

Authorized By: _____ Print Name : _____
Job Title: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax