RMH | OCCUPATIONAL MEDICINE

Company Data Form

Date: _____ Revised Date: _____

Business Name: _____

Address: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

Nature of Business: _____

Number of Employees: _____

WORK INJURY TREATMENT PROTOCOLS

Do you require post-accident drug screens? ❑ Yes ❑ No

Are you an E-Screen participant? ❑ Yes ❑ No ❑ Unknown

Limited Duty Available: ❑ Yes ❑ No

☑ **Evan Swanson, M.D. for Follow up**

☑ **RMH Orthopedic Care**

Is referral authorization required? ❑ Yes ❑ No

Contact Information: _____

☑ **Ransom Gollier Rehabilitation Physical Therapy, Occupational Therapy, Work Conditioning**

Is referral authorization required? ❑ Yes ❑ No

Contact Information: _____

☑ **Ransom Memorial Health Imaging Department for X-rays including MRI**

Is referral authorization required? ❑ Yes ❑ No

Contact Information: _____

Designated Pharmacy: _____

Guarantor: _____

_____

Work Comp Carrier Address: _____

_____

Other Key Contact Persons or Special Instructions: _____

_____