

New Company Information Sheet

Web Page: rmcareclinic.com

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1775 S. 4130 W., Salt Lake City, UT 84104
 Phone: 801-975-7799
 Fax: 801-975-7460



COMPANY INFORMATION		DATE: / /
Company Name:	Accounting Contact:	
Primary Contact:	Phone:	
Alternate Contact:	Fax:	
Phone:	Address:	
Address:		
City, State Zip	City, State Zip	
Fax:	Mobile Phone:	
Mobile Phone:	Email Address:	
E-Mail Address:		

SUBSTANCE ABUSE TESTING			
What type of tests will your company need? (check all that apply)			Reason for test
<input type="checkbox"/> NON-D.O.T. Test	<input type="checkbox"/> 5-Panel	<input type="checkbox"/> 9-Panel	<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Other
<input type="checkbox"/> D.O.T. Drug Test	<input type="checkbox"/> Breath Alcohol	<input type="checkbox"/> Hair Test	
<input type="checkbox"/> Collection Only	<input type="checkbox"/> Other		
How would you like your results reported? (check all that apply)			
<input type="checkbox"/> Fax	<input type="checkbox"/> Email	<input type="checkbox"/> Zeus	<input type="checkbox"/> Call In
Who is authorized to receive drug test results?			
Name:	Phone:	Fax:	Email:
Name:	Phone:	Fax:	Email:
Name:	Phone:	Fax:	Email:
Name:	Phone:	Fax:	Email:

RANDOMS									
How often would you like your randoms done?									
<input type="checkbox"/> Monthly	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black;">Total number of employees: #</td> <td></td> </tr> <tr> <td style="border-right: 1px solid black;">Total number of D.O.T employees: #</td> <td style="text-align: right;">%</td> </tr> <tr> <td style="border-right: 1px solid black;">Total number of Non-D.O.T employees: #</td> <td style="text-align: right;">%</td> </tr> <tr> <td colspan="2">Name, Social Security Number or Drivers License Number for random employee's</td> </tr> </table>	Total number of employees: #		Total number of D.O.T employees: #	%	Total number of Non-D.O.T employees: #	%	Name, Social Security Number or Drivers License Number for random employee's	
Total number of employees: #									
Total number of D.O.T employees: #		%							
Total number of Non-D.O.T employees: #		%							
Name, Social Security Number or Drivers License Number for random employee's									
<input type="checkbox"/> Quarterly									
<input type="checkbox"/> Annually									
<input type="checkbox"/> Other									
Special requests/requirements for randoms? _____									

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PHYSICALS/SCREENING/INDUSTRIAL SERVICES

- | <input type="checkbox"/> D.O.T. Physicals
<input type="checkbox"/> Pre-Employment Non-D.O.T. Physical
<input type="checkbox"/> Range of Motion and Strength Test
<input type="checkbox"/> Function Agility Test
<input type="checkbox"/> Audiogram
<input type="checkbox"/> P.F.T. Lung Test (with OSHA Questionnaire)
<input type="checkbox"/> Respirator Fit Test Qualitative-Smoke
<input type="checkbox"/> Respirator Fit Test Quantitative-Machine
<input type="checkbox"/> Full Face Mask/Type: _____
<input type="checkbox"/> Half-Face Mask/Type: _____
<input type="checkbox"/> Heavy Metal Panel Blood Draws
<input type="checkbox"/> Chest X-Ray
<input type="checkbox"/> EKG | <input type="checkbox"/> Hazmat Physical
<input type="checkbox"/> Respiratory Physical
<input type="checkbox"/> Hep A&B Vaccinations
<input type="checkbox"/> Function Capacity Evaluation
<input type="checkbox"/> Other
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="background-color: #cccccc;">Training</th> </tr> <tr> <td> <input type="checkbox"/> CPR
 <input type="checkbox"/> Reasonable Suspicion
 <input type="checkbox"/> Other </td> </tr> <tr> <th style="background-color: #cccccc;">Safety Supplies</th> </tr> <tr> <td> <input type="checkbox"/> Wall Cabinets
 <input type="checkbox"/> Vehicle Kits
 <input type="checkbox"/> Other </td> </tr> </table> | Training | <input type="checkbox"/> CPR
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<input type="checkbox"/> Other |
|--|---|----------|---|-----------------|---|
| Training | | | | | |
| <input type="checkbox"/> CPR
<input type="checkbox"/> Reasonable Suspicion
<input type="checkbox"/> Other | | | | | |
| Safety Supplies | | | | | |
| <input type="checkbox"/> Wall Cabinets
<input type="checkbox"/> Vehicle Kits
<input type="checkbox"/> Other | | | | | |

OTHER SERVICES NEEDED:

INJURY CARE INFORMATION (Insurance Company)

Company Name:
Primary Contact:
Phone:
Address:
Fax:
Mobile Phone:
E-Mail Address:
Account #:
Return to Work Contact:
Phone:
Alternate Contact:
Phone:

For Office Use Only:

<input type="checkbox"/> Zeus <input type="checkbox"/> Sales File <input type="checkbox"/> Cronus	Special Instructions: _____ _____ _____ _____
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Sales & Marketing Rep _____

New Company Information Sheet

Rocky Mountain Care Clinic, Inc. Payment Agreement

This agreement made and entered into on the _____ day of _____ 20__ between RMCC, hereafter referred to as RMCC, and _____ hereafter referred to as Client.

1. Invoices will be sent out weekly. Payment is due within 15 days of invoice.
2. Client agrees to pay all attorney fees, court costs, filing fees, and all collection costs. Cost up to 50% may be assessed by any collection agency retained to pursue past due accounts. Client further agrees to pay interest at the rate of 2% per month (24% per year) on all past due accounts.

I have read the above contract for payment and understand that I am or may be responsible for payment of the services I have received.

Client Name (Print)

RMCC

Client Signature

Date