Account Registration Information

Company Name: ____
Physical Address: ____

Local Address: same as above ___ or ____________________________________
Phone: (_____)______________________________ Fax: (_____)______________________________

So that we may better serve your needs, please give a brief description about your company:
____
____

About how many employees does your company employ locally? ______________________
Does your company follow OSHA regulations for recordable events in case of an injury? __________

How did you hear about Gulf Coast Occupational Medicine? __________________________
____

What made you decide to open an account with us? ____________________________

****Please provide a brief description of the medical services that you require (Drug/Alcohol screening, Physical exams, Respirator Fit Testing, etc…) or attach your company's medical screening protocol:**
____

BILLING

Contact Name for Billing: ____
Contact Number for Billing: (______)______________________________
Billing Address: ____
____
____
Attn:____

Email for invoices: ______________________________

TEST RESULTS

Please list the names and direct phone numbers of any persons who are able to receive results:

____ (_____)_____________________________

____ (_____)_____________________________

____ (_____)_____________________________

Emailing Results

Please list the email address to which you would like all results to be sent:

____

TPA (Third Party Administrator)

Company Name: ____

Contact: ____

Billing Address: ____

____

____

Phone: (_____)_____________________________ Fax: (_____)_____________________________

WORKERS COMP*Only Complete this section if you want GCOM to bill your Workers Comp Directly

Company Name: ____

Contact: ____

Billing Address: ____

____

____

Phone: (_____)_____________________________ Fax: (_____)_____________________________

PLEASE COMPLETE AND RETURN TO DANIELLE COWAN
E-MAIL: Danielle@gulfcoastoccmed.com
FAX: (225) 753-5188