



LOCATION OF INTEREST: KAPOLEI KAILUA PEARL CITY WAIKIKI
Please select all that apply

Company Name: _____ Contact Name: _____

Company Address: _____
Street Address City/State/Zip

Phone Number: _____ Fax Number: _____

Authorization List: _____
**Who is authorized to call on behalf of your employee or who are we allowed to speak to regarding results?*

BILLING INFORMATION

Do you want your statement printed? Yes No
 How would you like your statement printed?
 Summary (All employees on a single page)
 Detailed (Each employee on a single page)
 Both
 Would you like to include SSN on statement? Yes No

WORKERS COMPENSATION/WORK-RELATED INJURY INFORMATION

Is your company self-insured? Yes No
**If no, please fill out the following information*

Name of WC Insurance Company: _____

Address: _____
Street Address City/State/Zip

Contact Name(s): _____

Contact Number: _____ Fax Number: _____

****We will notify you if your employees' injury requires **First Aid Treatment vs. Workers Compensation** (OSHA Recordable).
 First Aid Treatment is billed directly to the company using our Fee for Service rates and not to the insurance carrier****

EMPLOYEE PAID SERVICES (EPS) INFORMATION

How would you like to pay for the services? Employee Employer Company HR Company Headquarters
** If address is same as company address above, you may leave the mailing section blank.*

Mailing Address: _____
Street Address City/State/Zip

Contact Name: _____ Contact Number: _____

Payments will be made attention to: _____

*HOW WOULD YOU LIKE US TO SEND THE RESULTS (PLEASE SELECT ONE)?	<input type="checkbox"/> Fax	<input type="checkbox"/> Mail	<input type="checkbox"/> Email	

*Please complete if you selected **mail**:*
 Mailing Address: _____
Street Address City/State/Zip

*Please complete if you selected **email**:*
 Email: _____ Email password: _____
To access results, please provide us with a customized **six-character password.*

*Please complete if you selected **fax**:*
 Fax Number: _____ Attention to: _____

EMPLOYER PAID SERVICES (EPS) SERVICES REQUESTED

Company Name: _____

First Aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>*Please note, if the injury does not meet First Aid guidelines, we will proceed to care for the employee based on the injury and this may become a Workers Compensation Claim</i>	
PHYSICALS				
Standard Physicals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Please select all that apply:</i>	<input type="checkbox"/> Basic <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Return-to-Work/Fit-for-Duty
DOT/CDL Physicals *SCHEDULING AVAILABLE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Exclusivity Tiers of Care (Updated July 2019)</i>	<input type="checkbox"/> DOT/CDL, standard - \$125
Tiers of Care are EXCLUSIVITY Rates; Your employees MUST come in with forms already completed and medical related conditions must meet the requirements of our checklist prior to coming in. Tiers are based on the complexity of the visit. Forms can be found ONLINE at our website: www.ucarehi.com .				
LAB SERVICES				
Drug Screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Please select all that apply:</i>	<input type="checkbox"/> Non-DOT Panel 5 <input type="checkbox"/> Non-DOT Panel 10 <input type="checkbox"/> DOT Panel 5 <input type="checkbox"/> Instant Panel 5 <input type="checkbox"/> Instant Panel 12 <input type="checkbox"/> DOT Drug Collection Only *Chain of Custody form must be LabCorp
Drug Testing MRO Services	<input type="checkbox"/> Use Urgent Care HI MRO <input type="checkbox"/> Provide own MRO *Chain of Custody Form must be LabCorp Name of MRO: _____ Address of MRO: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Street Address City/State/Zip </div> Phone Number: _____ Fax Number: _____			
Immunizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Tetanus <input type="checkbox"/> Flu <input type="checkbox"/> MMR <input type="checkbox"/> Hepatitis B Series (Series of 3 shots) <input type="checkbox"/> Hepatitis A (Series of 2 shots)	
Other Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Covid-19 RNA by PCR (Nasal Swab) <input type="checkbox"/> MMR Titer <input type="checkbox"/> Hep B Titer <input type="checkbox"/> Varicella Titer <input type="checkbox"/> Covid-19 Rapid Antigen Test (Nasal Swab) <input type="checkbox"/> Covid-19 Antibody (Blood Test) <input type="checkbox"/> Others (please specify) _____	
PROCEDURES				
Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> EKG <input type="checkbox"/> Spirometry	
TB Clearance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Risk Assessment <input type="checkbox"/> Skin Test <input type="checkbox"/> Chest Xray	
Respirator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Respirator Clearance *Comes with Clearance Card <i>(*Will proceed to Respirator Physical Exam if employee fails Respirator Questionnaire)</i> <input type="checkbox"/> Respirator Physical Exam <input type="checkbox"/> Qualitative Respirator Fit Test <i>(*Employee must bring their own mask and copy of their clearance card)</i>	
Alcohol Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DOT	

Other Special Instructions: **Please feel free to attach any additional documents for review*

Upon completing, our Occupational Medicine Specialist, Maria Rica Cunanan will reach out to you.
Phone: 808.521.2273 | Email: occmcd@ucarehi.com