CENTRAL OCCUPATIONAL MEDICINE PROVIDERS

Courtesy Transportation Available 24 Hours a Day / 7 days a week for *Initial Injury Visit*
Visit us at: https://www.comp-medicalgroup.com

New Client ☐ **Account Update ☐**

EMPLOYER REGISTRATION PACKET

(Please email form to customerservice@cenocc.com)

Company Name:_____ **Standard Industrial Classification (SIC) #**_____

Location Address:_____ City:_____ State:_____ Zip:_____

Type of Business:_____ Hours of Operation:_____ # of Employees: _____

Does your Company use Temp/Staffing Agency? ☐ YES ☐ NO If yes, which **Staffing Agency**? _____

Corporate Name (*if applicable*): _____

Corporate Address:_____ City:_____ State:_____ Zip: _____

INJURY CONTACT INFORMATION

Primary Contact Person: _____ ☐ With Location ☐ With Corporate Office

Email Address:_____ Phone #:_____ CP #:_____ Fax: _____

Secondary Contact Person: _____ ☐ With Location ☐ With Corporate Office

Email Address:_____ Phone #:_____ CP #:_____ Fax: _____

After Hours Contact Person: _____ ☐ With Location ☐ With Corporate Office

Email Address:_____ Phone #:_____ CP #:_____ Fax: _____

PRE-EMPLOYMENT CONTACT INFORMATION

Primary Contact Person: _____ ☐ With Location ☐ With Corporate Office

Email Address:_____ Phone #:_____ CP #:_____ Fax: _____

Secondary Contact Person: _____ ☐ With Location ☐ With Corporate Office

Email Address:_____ Phone #:_____ CP #:_____ Fax: _____

WORKERS COMP INSURANCE CARRIER / CLAIMS ADMINISTRATOR

Is Company Self Insured? ☐ Yes ☐ No

**Company named above is assumed authorized and is responsible for payments to COMP. If not, please attach Certificate of Insurance and provide following information:

Insurance Carrier:_____ Policy #:_____ Expiration Date: _____

Mailing Address**:**_____ City:_____ State:_____ Zip:_____

Assigned Adjuster**:**_____ Phone #:_____ Fax:_____

Email Address: _____

Please provide information below if applicable:

TPA / Claims Administrator: _____

Mailing Address**:**_____ City:_____ State:_____ Zip:_____

Assigned Adjuster**:**_____ Phone #:_____ Fax:_____

Email Address: _____

*Claim # for Injuries must be submitted to COMP within 5 days from DATE of SERVICE, Claim #s can be emailed directly to claimnos@cenocc.com

DRUG TEST INFORMATION – TPA OR LABORATORY USED (*if applicable*)

TPA:_____ **Laboratory Used:** _____

Send results to:_____ Phone #:_____ Fax:_____

Mailing Address**:**_____ City:_____ State:_____ Zip: _____

Email Address: _____ Preferred method for test result correspondence: Email_____Fax_____Call_____Mail_____

_____ **EMPLOYER'S AUTHORIZED SIGNATURE** _____

***Print Name** ***Sign**

*not necessary if this page is submitted as a complete packet

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Company Name: _____

SERVICES PROTOCOL INFORMATION (INJURY)

Follow Written Authorization if different from Company Protocol? ☐ YES ☐ NO

Please note that **PROPERLY SIGNED AUTHORIZATION FORMS are required for treatment.

Allow verbal authorization? ☐ YES ☐ NO

Do you or your Insurance Carrier use a Durable Medical Equipment Program? ☐ YES ☐ NO

Do you or your Insurance Carrier use a Pharmacy Prescription Program? ☐ YES ☐ NO

Allow Transportation Authorization for Services other than First Injury? (Additional fees will apply) ☐ YES ☐ NO

Accommodations for Modified Work Available? ☐ YES ☐ NO

Need Online Access for Medical Reports, Physicals, Drug Results, and Account Status Report? ☐ YES ☐ NO.

***For all contacts provided on page 1? ☐ YES ☐ NO. If no, please provide the following contact information for those additional individuals you want to have access.

Name: _____ Phone no. _____ - _____ - _____ Email: _____

Name: _____ Phone no. _____ - _____ - _____ Email: _____

Name: _____ Phone no. _____ - _____ - _____ Email: _____

INJURY to the employee protocol:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non-Negative ☐ YES ☐ NO

☐ Drug Screen through COMP's Lab NIDA ☐ NON-NIDA ☐

☐ Oral Swab Drug Screen (Intercept) NON-NIDA (THC Only) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (7 Panel) ☐

☐ Urine Collection (*Drug Test*) – Send to your Lab: Laboratory: _____ Account #;_____

☐ Hair Collection (*Drug Test*) – ☐ NIDA (5 Panel) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (10 Panel)

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: _____

ACCIDENT OR COLLISION without injury to the employee:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non-Negative ☐ YES ☐ NO

☐ Drug Screen through COMP's Lab NIDA ☐ NON-NIDA ☐

☐ Oral Swab Drug Screen (Intercept) NON-NIDA (THC Only) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (7 Panel) ☐

☐ Urine Collection (*Drug Test*) – Send to your Lab: Laboratory: _____ Account #;_____

☐ Hair Collection (*Drug Test*) – ☐ NIDA (5 Panel) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (10 Panel)

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: _____

_____ **EMPLOYER'S AUTHORIZED SIGNATURE** _____
***Print Name** ***Sign**

*not necessary if this page is submitted as a complete packet

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Company Name: _____

SERVICES PROTOCOL INFORMATION (PRE-EMPLOYMENT)

PRE-EMPLOYMENT SERVICES for the employee:

A. DRUG TESTING REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Instant Drug Test (*Quick Test*) ☐ 5 Panel ☐ 10 Panel With Confirmation on Non-Negative ☐ YES ☐ NO

☐ Drug Screen through COMP's Lab NIDA ☐ NON-NIDA ☐

☐ Oral Swab Drug Screen (Intercept) NON-NIDA (THC Only) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (7 Panel) ☐

☐ Urine Collection (*Drug Test*) – Send to your Lab: Laboratory: _____ Account #;_____

☐ Hair Collection (*Drug Test*) – ☐ NIDA (5 Panel) ☐ NON-NIDA (5 Panel) ☐ NON-NIDA (10 Panel)

B. BREATH ALCOHOL TEST REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Special Instructions/ REMARKS: _____

C. PHYSICAL EXAM REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

Physical Description **(Service Times 8:30am-4:45pm (Mon-Fri) except Holidays)**

☐ Basic Biometric Physical Exam: (includes Medical History Review, Medical Examination, Blood Pressure, Vitals & Basic Near/Far Vision)

☐ Standard Intermediate Physical Exam (includes Medical History Reviewed, Medical Examination, Blood Pressure, Vitals, Vision (Near, Far, Peripheral and Basic Color), Urinalysis and Audiogram)

☐ DOT Physical

☐ Return to Work (fit for duty) Physical Exam ☐ Audiogram Only ☐ Vision Only

☐ Respiratory Physical Exam

☐ Hazmat Physical Exam ☐ Hazwoper Physical Exam

Special Instructions/ REMARKS: _____

D. ADDITIONAL SERVICES REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Physical Ability Test with Lift Testing and Back Training_____Lbs

☐ Lift and Carry Functional Testing with Back Training_____LBS

☐ EDEX (background check on permanent work restrictions {must be done in combination with a Physical})

☐ JAMAR (Grip Strength Measurement Using Special Equipment)

☐ Pulmonary Function Test w/ Respiratory OSHA Questionnaire

☐ Mask Fit ☐ N95

☐ OSHA Respirator Questionnaire w/ Physician Review

☐ Chest X-Ray ☐ 1 View ☐ 2 Views ☐ B-Read Chest X-Ray (NIOSH Certified – Exposure)

☐ Back X-Ray ☐ 2 Views ☐ 3 Views

☐ PPD / TB Skin Test ☐ QuantiFERON (IGRA TB Blood Test)

Special Instructions/ REMARKS: _____

E. INJECTIONS REQUIRED: ☐ Yes ☐ No ☐ Upon Request ONLY

☐ Tetanus

☐ T-dap

☐ Varicella Vaccine

☐ Hepatitis B 3 series

☐ MMR Vaccine

_____ **EMPLOYER'S AUTHORIZED SIGNATURE** _____
***Print Name** ***Sign**
*not necessary if this page is submitted as a complete packet

Company Name: _____

Workers Compensation Compliance Notices

CLAIM FORM, FIRST AID

5401. (a) Within one working day of receiving notice or knowledge of injury under Section 5400 or 5402, which injury results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid, the employer shall provide, personally or by first-class mail, a claim form and a notice of potential eligibility for benefits under this division to the injured employee, or in the case of death, to his or her dependents.

As used in this subdivision, "first aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel. "Minor industrial injury" shall not include serious exposure to a hazardous substance as defined in subdivision (i) of Section 6302. The claim form shall request the injured employee's name and address, social security number, the time and address where the injury occurred, and the nature of and part of the body affected by the injury. Claim forms shall be available at district offices of the Employment Development Department and the division. Claim forms may be made available to the employee from any other source.

PROVISION OF CARE and LIABILITY FOR CLAIM

5402. (a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.

(c) Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

(d) Treatment provided under subdivision (c) shall not give rise to a presumption of liability on the part of the employer.

Acknowledgement:

Employer Representative's Name:_____ Date:_____
Print

Employer Representative's Signature:_____

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Company Name: _____

BILL TO INFORMATION

Recordable Claim: ☐ Insurance Carrier ☐ TPA

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Email: _____ Phone #: _____ Fax #: _____

First-Aid: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ TPA _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Email: _____ Phone #: _____ Fax #: _____

Non-Industrial: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ TPA _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Email: _____ Phone #: _____ Fax #: _____

Post Injury Drug Test/BAT: ☐ Company ☐ Corporate ☐ Insurance Carrier ☐ TPA _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Email: _____ Phone #: _____ Fax #: _____

Claim Number Contact Person: _____

Email: _____ Phone #: _____ Fax #: _____

Claim # for Injuries must be submitted to COMP with **5 days from DATE of SERVICE, Claim #s can be emailed directly to **claimnos@cenocc.com**

Pre-Employment bills to: ☐ Company ☐ Corporate ☐ Laboratory ☐ TPA _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Email: _____ Phone #: _____ Fax #: _____

All Invoices are due **45 days from postage date to be in compliance. **Finance charges of 15% and penalty charges of 10%** will be imposed for Late Payments after the Due Date indicated.

Employer Representative's Name: _____ Title: _____
Print

Employer Representative's Signature: _____ Date Submitted: _____

Marketer's Name: _____ Email: _____
Print

Marketer's Signature: _____

Mobile Occupational Services, Inc.
Partners for a Quality Workforce
11687 Hesperia Rd • Hesperia, California 92345 • (760) 244-6886

MRO REPORTING PROTOCOL FORM

The following form is used to setup the MRO reporting protocol for your organization. Please provide the Designated Employer Representative and an alternate in case the primary contact is not available. If you need to add or update any information please contact our office or submit this form again. If you have any questions please contact us at 760-244-6886.

Company Information

Company Name _____

Address _____

City _____ State _____ ZIP _____

Contact Information

Primary Contact _____

Phone _____ Fax _____

e-mail _____

For test result correspondence - please ✓ Preferred method(s)

e-mail____	Call & Mail____	Fax____	Mail ONLY____

Alternate Contact _____

Phone _____ Fax _____

e-mail _____

For test result correspondence - please ✓ Preferred method(s)

e-mail____	Call & Mail____	Fax____	Mail ONLY____

Special instructions for test result correspondence (If needed) _____

_____

_____

Central Occupational Medicine Providers currently logs and organizes your test results for online access. In order to continue this third party administrative service, please provide signature approval below from the Designated Employer Representative.

Signature: _____ Print Name:_____ Date:_____