CONE HEALTH
Occupational Health & Wellness

Occupational Health & Wellness Company Profile

Please email the completed form to employerhealth@conehealth.com.

Company Information

Company Name _____ Number of Employees _____

Company Address _____

City _____ State _____ Zip _____

Main Contact Name/Title _____

Main Contact Phone _____ Fax _____

Main Contact Email _____

Secondary or Billing Contact Name/Title _____

Secondary or Billing Contact Phone _____ Fax _____

Secondary or Billing Contact Email _____

Preferred Communication Method _____

Online Portal Access

As a valued client, you will receive 24/7 access to **iSystoc**, an online portal where you can retrieve drug screen results, work status restrictions, physical clearance, and other results.

Which of the above contacts need access to this portal? An email will be sent to these individuals with login and password information and portal instructions.

☐ **Main Contact Person** ☐ **Secondary Contact Person** ☐ **Billing Contact Person**

Worker's Compensation

If we provide Workers Compensation services to your employees, **do you require post-accident drug screens and/or breath alcohol testing?** If yes, please indicate one or both services.

☐ **Drug Screen** ☐ **Breath Alcohol**

Billing Instructions: Please indicate where bills should be sent for Workers Compensation. Bills cannot be sent to both the client and the carrier, so please select **only one option**.

◯ **Direct to Client** ◯ **Workers Compensation Carrier/Insurance Company**

Workers Comp Carrier/Insurance Company Name _____

Address _____

City _____ **State** _____ **Zip** _____

Policy # _____ **Dates of Coverage: from** _____ **to** _____

***Please supply updated coverage information any time there is a change/renewal in your carrier.
This will allow us to update our system and send information to the appropriate carrier in a timely manner.

**We accept electronic payments and credit card payments (Visa, MasterCard, and Discover).
If you would like to utilize these payment methods, please contact our office at (336) 890-4475.**

Occupational Health & Wellness Services

What types of services are you interested in? Please indicate as many services as needed.

☐ Drug Screen	☐ Physicals
☐ Breath Alcohol Testing	☐ DOT Physicals
☐ Lab Work	☐ Respiratory Screening
☐ Physical Capacity Profile (PCP) Testing	☐ Travel Medicine
☐ Immunizations	☐ Workers Compensation Injury Care

☐ Other: _____