CORPORATE ACCOUNT INFORMATION SHEET

Client Information:

Company Name: ____

Address: ____

____

Tax Identification Number: ____________________________

Contact Person: ______________________________________

Telephone Number: ____________________

Fax Number: _________________________

Please provide the following:

Trade References:

(1) Name: ____

Address: ____

____

Phone Number: ______________ Account Number: ________________

Contact Person: ________________________________

(2) Name: ____

Address: ____

____

Phone Number: ______________ Account Number: ________________

Contact Person: ________________________________

(3) Name: ____

Address: ____

Banking Information:

Bank Name: ____

Address: ____

____

Phone: ____

Contact Person: ________________________________

Account Number: _________________________

Workers Compensation Insurance Information:

Company Name: ____

Address: ____

____

Contact Person: ____

Telephone Number: ____

Fax Number: _______________________

Policy Number: _____________________

When an employee is injured on the job, would you like for us to drug test them on their first visit to the clinic?

__ Yes __ No

Do you intend to use our facility for any of the following?

__ Pre-employment drug testing
__ Random drug testing
__ NITA drug testing
__ Flu vaccinations
__ Workers Comp. Accidents
__ Pre-employment physicals
__ DOT physicals
__ Hepatitis B vaccinations
__ TB testing
__ Etc. _________________