FOR XPRESS OFFICE USE ONLY:
Staff Name: _____
Clinic: _____
How was this discussed?
☐ Verbally ☐ In-person

XpressWellness URGENT CARE
XpressWellnessUrgentCare.com

EMPLOYER PROTOCOLS

COMPANY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ FAX _____

PRIMARY CONTACT (DER) _____

PHONE _____ FAX _____

EMAIL _____

EMPLOYEES WHO CAN AUTHORIZE SERVICES TO BE ADMINISTERED AT XPRESS WELLNESS

NAME _____ PHONE _____

NAME _____ PHONE _____

NAME _____ PHONE _____

EMPLOYEES AUTHORIZED TO RECEIVE RESULTS

NAME _____ PHONE _____

EMAIL _____

NAME _____ PHONE _____

EMAIL _____

NAME _____ PHONE _____

EMAIL _____

PLEASE FILL OUT BILLING INFORMATION ON FOLLOWING PAGE

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EMPLOYER PROTOCOLS

BILLING INFORMATION for EPS SERVICES Payment terms are net 30.

BILL TO: ☐ Directly to Employer ☐ Third Party Administrator (TPA) ☐ Other _____

IF BILLING **DIRECTLY TO EMPLOYER**, WHO DOES THE BILL NEED TO GO?

NAME_____ PHONE_____

HOW DO YOU PREFER TO RECEIVE STATEMENTS? ☐ Email ☐ Mail
EMAIL TO/MAIL ADDRESS:_____

IF BILLING **TO THIRD PARTY ADMINISTRATOR**

TPA COMPANY NAME _____

PRIMARY CONTACT_____ PHONE_____

EMAIL_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

MAIN PHONE_____ FAX_____

BILLING INFORMATION for WORKER'S COMP Payment terms are net 30.

BILL TO: ☐ Directly to Employer ☐ Worker's Comp Insurance

IF BILLING **DIRECTLY TO EMPLOYER** , WHO DOES THE BILL NEED TO GO TO?

NAME_____ PHONE_____

HOW DO YOU PREFER TO RECEIVE STATEMENTS? ☐ Email ☐ Mail
EMAIL TO/MAIL ADDRESS:_____

IF BILLING TO **WORKER'S COMP (WC) INSURANCE**:

WC INSURANCE NAME _____

PRIMARY CONTACT_____ PHONE_____

EMAIL_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

MAIN PHONE_____ FAX_____

POLICY NUMBER_____ GROUP NUMBER_____

EFFECTIVE DATE OF INSURANCE_____

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EMPLOYER PROTOCOLS

PHYSICALS

☐ DOT ☐ Pre-Employment ☐ Bus Driver ☐ Other (please specify specific needs below)

URINE DRUG SCREENS (UDS)

Rapid[1]

- ☐ 4 panel (excludes THC)
- ☐ 5 panel
- ☐ 10 panel

☐ Non-DOT Send Out

Do you have your own COC?

❍ Yes ❍ No

☐ DOT Send Out

Do you have your own COC?

❍ Yes ❍ No

Testing Agency/Authority
(must choose one for DOT)

❍ FMCSA ❍ PHMSA ❍ FAA
❍ FTA ❍ HHS ❍ NRC
❍ FRA ❍ USCG

BREATH ALCOHOL TEST (BAT)

☐ DOT
☐ Non-DOT

☐ HAIR FOLLICLE

Do you have your own COC?

❍ Yes ❍ No

OTHER

- ☐ Flu Vaccine
- ☐ Hepatitis B Vaccine
- ☐ Tetanus Shot
- ☐ TB/PPD Skin Test
- ☐ Lift Test (_____ pounds)
- ☐ Hearing Test[2]
- ☐ Jamar Grip Test
- ☐ Respiratory Fit Test[2]
- ☐ Pulmonary Function Test[2]
- ☐ Chest X-ray (2 view)
- ☐ Lumbar X-ray
- ☐ EKG
- ☐ Other_____

☐ Vision Test

- ❍ Snellen (far)
- ❍ Jaeger (near)
- ❍ Ishihara (color)