



SSM WorkHealth

A Service of SSM Rehabilitation Hospital

Company Account Profile

Company Name: _____

Mailing Address: _____

of Employees: _____ Type of Business _____

PHYSICALS:

Contact Person	Phone #	FAX #	Email
_____	_____	_____	_____

WORKERS' COMP:

Contact Person	Phone #	FAX #	Email
_____	_____	_____	_____

DRUG SCREENING:

Contact Person	Phone #	FAX #	Email
_____	_____	_____	_____

Work Injury Drug Screen Program: _____ yes **(Please complete page 2)**
_____ no

ACCOUNTS PAYABLE:

Contact Person	Phone #	FAX #
_____	_____	_____

Workers' Compensation Insurance Information

Carrier: _____

Mailing Address: _____

Telephone #	FAX #
_____	_____

Policy #	Effective Date
_____	_____

Additional services requested: (i.e.-audio programs) **(Please complete page 2)**

Please indicate any special instructions that you want to be noted in your company profile. (Examples: Drug screen all WC injuries; Mail physical results to Mrs. Jones @ Company X; Call Mrs. Smith @ Company Y with drug screening results; Mrs. Brown is the only company representative to authorize treatment, etc.)

Name of company representative completing this form

Phone #

Date

