CRUCIAL CARE®
EMERGENCY MEDICINE DOCTORS

crucialcare.com

WORKERS COMPENSATION PRE-ARRIVAL FORM

COMPANY

Company Name: _____

Contact: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

EMPLOYEE

Employee Name: _____

Employee SSN: _____

Phone: _____

INJURY

Date of Injury: _____

Claim Number: _____

Carrier Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Fax Date: _____

Pages: _____

FAX TO: (904) 854-7912

If you are requesting a drug test, please send a statement on company letterhead requesting the drug test. Include reason for the drug test, list of drugs to be tested for, signature of employer authorizing drug test OR chain of custody.