

# New Account Information

COMPANY NAME: \_\_\_\_\_

COMPANY ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ FAX: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

NUMBER OF EMPLOYEES: \_\_\_\_\_

WORKERS COMP. INSURANCE: \_\_\_\_\_

ADDRESS OF INSURANCE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>SERVICES NEEDED:</b>	<input type="checkbox"/> TB TEST
<input type="checkbox"/> DRUG SCREENS	<input type="checkbox"/> TETANUS
<input type="checkbox"/> BREATH ALCOHOLS	<input type="checkbox"/> HEP. B SERIES
<input type="checkbox"/> COMP. TREATMENT	<input type="checkbox"/> PHYSICALS
<input type="checkbox"/> FLU SHOTS	<input type="checkbox"/> RANDOM PULL
<input type="checkbox"/> OTHER _____	
_____	
_____	

**Emergicare of Harrisonburg, Inc.**

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