Industrial Medical Group
OF SANTA MARIA VALLEY

New Account Information

Company Name: _____ **Contact Person:** _____

Address: _____ **Email:** _____

_____ **Phone:** _____

☐ **Same as above / Billing Address:** _____ **Fax:** _____

_____

Services Request

Mark each medical service that you would like us to perform

Medical Exam Types

Basic Medical Physical Exam	
DMV/DOT Medical Exam	
Haz-Mat Physical Exam	
Scape Physical Exam	
Fit for Duty Physical Exams	
Pre-Employment Physical Exam	
Travel Physical Exam	

Vaccines

Tetanus (dT)	
Tdap Tetanus/Pertussis	
Flu Shot	
Hepatitis A	
Hepatitis B	

Laboratory Testing

Hepatitis B Titer	
MMR Titer	
Varicella Titer	
Complete Blood Count and Chemistry Panel (CBC with Chem)	
Lipids (Cholesterol/Triglycerides)	
Cholinesterase	
Thyroid Panel	
Heavy Metals	
Lead	
Zinc Protoporphyrin (ZPP)	
PSA	

Other Medical Components

Health Screen Questionnaire Review	
Urinalysis (UA Dip Test)	
Urinalysis (UA Complete)	
Chest X-Ray 1 View	
Chest X-Ray 2 Views	
Back X-Ray	
Back Flexibility	
Back Strength Exam	
Respirator Questionnaire	
Pulmonary Function Testing (PFT)	
Electrocardiogram (EKG)	
Cardiac Stress Test	
Audio Exam	
Hemocult	
Complete Vision	
Screening Sleep Study	
Tuberculosis Skin Test (PPD)	
Respirator Fit Testing	

Safety Training

Cardiopulmonary Resuscitation (CPR)	
First Aid Training	
Supervisor Drug and Alcohol Awareness	

Special Request:

_____

_____

_____

Drug & Alchohol Testing

Industrial Medical Group as your company Medical Review Officer (MRO)

IMG DOT Drug Testing Program	
Afterhours Drug & Alcohol Service	
Drug Screening DOT or Non-DOT	
Quick Test Drug Screening	
Breath Alcohol Testing DOT or Non-DOT	

Collection Only	

Name of Company MRO: _____

Phone: _____

Fax: _____

Address: _____

_____

Afterhours Drug & Alcohol Service	
Drug Screening DOT or Non-DOT	
Breath Alcohol Testing DOT or Non-DOT	

Worker Compensation Injury Treatment

Treatment to Industrial First Aid Injuries	
Treatment to Industrial Reportable Injuries	

Name of Worker Compensation Insurance: _____

Policy Number: _____

Phone: _____

Address: _____

_____

Send Results to:
Email Address:
Faxed: Yes / No **Cover Sheet Required:** Yes / No
Fax Number:
Mailed: Yes / No
Mailing Address:

If you have marked all the medical services that you would like IMG to provide your company. Please complete the information below and fax it back to our office. Once our office receives this form, someone from our staff will contact you regarding protocols, pricing, scheduling and authorizations.

Print Name: _____ Signature: _____

Job Title: _____ Date: _____

Phone: (805) 922-8282 **Fax: (805) 925-2690**

3070 Skyway Drive, Ste. 106 Santa Maria, CA 93455