

**APPLICATION FOR POST-INJURY
DRUG AND/OR ALCOHOL TESTING PROGRAM**

TO: FHM Underwriting Department	Fax No: 407-373-6441	Date:	
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INFORMATION NEEDED TO REGISTER YOUR COMPANY

(Please complete all information on this page and fax to FHM Policy Services Department)

GENERAL INFORMATION

Policy No.	306-		
Company Name :			
D/B/A:			
Street:			
City:		State:	Zip:
Phone:		Fax:	
Contact:		Email:	

YES, I am interested in registering my Company for this program:

MANAGED CARE PROVIDER INFORMATION

(Where you send your injured employee for treatment)

Provider Name:			
Street:			
City:		State:	Zip:
Phone:		Fax:	
Contact:		Email:	

Provider Name:			
Street:			
City:		State:	Zip:
Phone:		Fax:	
Contact:		Email:	

NO, I am not interested in registering my Company for this program:

Reason please: _____

PLEASE NOTE: Your company will be responsible for the costs of drug tests conducted at a designated medical center or collection site for tests that are **NOT** part of the FHM "Post-Accident Drug Testing Program" (examples are: (1) Post-accident testing in which a claim is not reported; (2) Pre-Employment; (3) Random & reasonable suspicion). Also, you are **NOT** set-up to do post-accident testing until you receive "chain of custody" forms and further instructions from **Total Compliance Network (TCN)** – (800) 881-4826.

Company Official's Signature:			
Print Name :		Title:	