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

TO:	FHM	Fax No. 407-373-6441	Date:	

INFORMATION NEEDED TO REGISTER YOUR COMPANY

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

GENERAL INFORMATION

FHM Policy No.	WC-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:

Authorized PROVIDER INFORMATION

(Where you send your injured employees for treatment)

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

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

TO DECLINE:

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

Reason please: ______________________________

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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 Testing; (3) Random & Reasonable Suspicion Testing). You are **NOT** ready to do post-injury testing until you receive ***"chain of custody"*** **forms** and further instructions from **Total Compliance Network (TCN) – (800)881-4626**.

Company Official's Signature:			
Print Name:		Title:	