Decatur County Memorial Hospital
The Quality Care You Want. Close By.

WorkWell Enrollment Form

Please complete all fields below. Help us understand your company's needs so we can tailor our occupational health services to best support your team.

Company Name: _____
Number of Employees: _____
Contact Person First and Last Name: _____
Contact's Phone: _____ Contact's Email: _____ Contact's Fax: _____
Preferred Method of Contact (Select One):
☐Email ☐Fax

Company Mailing Address
Street: _____ City: _____ State: __ ZIP: _____

Company Billing Address (If Different from Mailing)
Street: _____ City: _____ State: __ ZIP: _____

Workers' Comp Insurance Information
Workers' Comp Insurance Company Name: _____
Contact Person First and Last Name: _____
Contact's Phone: _____ Contact's Email: _____ Contact's Fax: _____
Workers' Comp Company Billing Address:
Street: _____ City: _____ State: __ ZIP: _____

Services – Please Select All the Services You Need:
Physical Examinations:
☐DOT ☐Forklift ☐Respirator ☐Non-DOT/Preemployment ☐Return to Work
Drug Screens:
☐DOT ☐5 Panel Instant ☐10 Panel Instant ☐5 Panel Send Out (Lab) 10 Panel Send Out (Lab)
☐Saliva ☐Hair Follicle ☐Collection ONLY ☐BAT
Tuberculosis Testing:
☐PPP ☐2-Step ☐Chest X-ray ☐QuantiFERON
Immunizations:
☐Hepatitis A ☐Hepatitis B ☐Influenza ☐T-Dap ☐COVID ☐Titers
Do You Need to Enroll in Random Drug Screen Pool?
☐Yes ☐No
Other Testing:
☐Audio ☐Human Performance Evaluation ☐FIT Testing ☐Other: _____
Injury Care:
☐Yes ☐No