# Employer Preference Sheet

*Please return via email to sales@applecaredoctors.com*

Organization _____

Contact Name _____ Title _____

Company Phone _____ Fax _____ Email _____

Company Address _____

City _____ State _____ Zip _____

**Workers Compensation Carrier/TPA** *(Optional)*

Name _____
Address _____
Suite # _____
City _____
State _____ Zip _____
Email _____
Phone _____
Fax _____

**Occupational Medicine TPA** *(Optional)*

Name _____
Address _____
Suite # _____
City _____
State _____ Zip _____
Email _____
Phone _____
Fax _____

**PLEASE NOTE BELOW ALL OPTIONS THAT APPLY**

**Workers Compensation**
- ☐ Authorized to Dispense Meds
- ☐ Post Accident Drug Screen

**Occupational Medicine**
- ☐ DOT Physical ☐ Non DOT Physical
- ☐ DOT Drug Screen ☐ Non DOT Drug Screen

**Lab and Panel Options**
- ☐ LabCorp ☐ Quest ☐ Sepa ☐ Other
- ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel

**Results:**
- ☐ MCup ☐ E Screen
- ☐ Instant ☐ Send Out

**NOTES:** _____

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**Medical Review Office** *If left blank, AppleCare will act as MRO*

Name _____

Address _____ Suite # _____

City _____ State _____ Zip _____

Email _____ Phone _____

Fax _____

**AUTHORIZED BY:** *We (Employer) are authorizing AppleCare to provide treatment to employee. By doing so, we acknowledge that we are responsible for payment of any/all services in the event a claim is not filed and paid on our behalf.*

Name _____ Signature _____

Title _____ Date _____