2101 N. Waldron, Hutchinson
24 South Main, South Hutchinson
1100 N. Main, Hutchinson
619 N. Main, McPherson

Employee Accident Form

Name _____ Date _____ Time _____am/pm

Address _____

Phone _____ DOB _____ SSN _____

Company _____

Company Contact/Supervisor _____ Phone # _____

Supervisor Email _____

Work Comp Insurance Provider*_____

***Work Comp provider information must be received within 30 days of this visit. If this information is not provided to us, the charges will be patient responsibility.**

If not accompanied by company representative, is your company or supervisor aware of this accident?
Yes_____ No_____

Authorized by _____ _____ Date _____

Post Accident Screening

Drug and Breath Alcohol tests require photo identification.

◯ **Post Accident Drug Screen DOT** ◯ **Post Accident non DOT** ◯ **Breath Alcohol**

◯ 5 Panel Drug Screen

◯ 7 Panel Drug Screen

◯ 10 Panel Drug Screen