EMPLOYER PORTAL ACCESS

Company Name _____ Date _____

Address _____

Authorized Company representative _____ Phone_____

Contact 1

Name _____

Email _____

Access to all Records yes ☐ No ☐

If No, check off below which access is needed

- ☐ Breath Alcohol
- ☐ Drug Screens
- ☐ DOT
- ☐ Injury Discharge Summary
- ☐ Physicals
- ☐ Tuberculosis screening
- ☐ Lab work
- ☐ PPE Physical's
- ☐ Respirator Exam

Contact 2

Name _____

Email _____

Access to all Records yes ☐ No ☐

If No, check off below which access is needed

- ☐ Breath Alcohol
- ☐ Drug Screens
- ☐ DOT
- ☐ Injury Discharge Summary
- ☐ Physicals
- ☐ Tuberculosis screening
- ☐ Lab work
- ☐ PPE Physical's
- ☐ Respirator Exam

*****Please email the completed form to : Billing@occmedconnect.com or fax to: 734-333-8005.**

Please expect an email with login information within 1-2 business days of sending the form.