

Para-Medical Examination Request Form

Date: _____ Examiner Name: OHP

Insurance Company Name: _____

Agency Name : _____ Agent Name: _____

Agent Code: _____

Agent Phone:(_____) _____ Agent FAX:(_____) _____

Agent E-mail: _____

Applicant/Client Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work or Cell Phone: _____

E-mail Address: _____

Date of Birth: _____ Social Security: _____

Special Instructions for Contacting Applicant:

Amount of Policy: _____ Policy No: _____

Company Requirements (Check all that Apply):

ParaMed _____ HOS/Urine Specimen _____ Blood Profile _____

Measurements/Vitals _____ EKG _____ Saliva _____ MD Exam _____

Special Communication Instructions:

Send Paperwork to: Insurance Company _____ Agent _____

Mail _____ FAX _____ E-mail _____

Other: _____