EMC OnCall Nurse: *Enrollment Details*

NOTE: *Enrollment is required prior to using the triage service. Please email the completed form to Claims.OnCallNurse@emcins.com or click Submit Form button at the bottom. An EMC team member will confirm once enrollment has been finalized.*

Workers' Compensation Contact Information

This individual will receive the EMC OnCall Nurse/Medcor incident report and first report of injury:

W/C Contact Name: _____

Email: _____

Phone: _____

Company Information

Company Name: _____

DBA (if applicable): _____

Mailing Address: _____

List all physical company addresses and location names or attach a list of locations:

_____

_____

_____

Do you have an off-site/mobile workforce? Yes ◯ No ◯

Preferred Medical Clinics for work-injury care (select one):

◯ We would like assistance in finding preferred clinics in the area

◯ We would like to use the directory (the nurse will offer a nearby clinic to the injured worker at the time of the call)

◯ We would like to use our preferred clinics (please list clinic info below, exclude hospitals)

_____

_____

Enrollment Materials

Printed copies, and an electronic version, will be provided upon enrollment.

How many hard copies of each would you like to receive: Posters Wallet Cards Stickers

◯ Check this box if you do NOT wish to receive printed, hard copies

CLEAR FORM SUBMIT FORM*

*The "SUBMIT FORM" function is only compatible with Chrome, Firefox, Safari and Edge.
Completed enrollment forms can also besaved and returned via email to: claims.oncallnurse@emcins.com