



Company Request Form

Business Name:			
ABN:		A C N:	
Trading as:			
Postal Address:			

Details of authorised contacts				
Name:		Position:		
Email:		Phone:		Fax No:
Name:		Position:		
Email:		Phone:		Fax No:

Payment Options	
<i>Please tick where appropriate.</i>	
<p style="text-align: center;">Direct Deposit EFT:</p> <p>Account Name: 4cRisk Bank: Suncorp BSB: 484 799 Account No: 201509365 <i>Please send copy of remittance advice to 4cRisk on the day of deposit.</i> Fax: 07 3839 1557 or email: accounts@4cRisk.com.au</p>	<p style="text-align: center;">Cheque:</p> <p>To be sent to – 4cRisk Suite 8 Level 6 201 Wickham Terrace BRISBANE QLD 4000</p>

Please indicate which services you are interested in		
PRE-EMPLOYMENT	EMPLOYED	ADDITIONAL
Base medical	Periodic Medical	Injury Management
Audiometry	Vaccinations	Pre-insurance Medical
Spirometry	Functional Performance	Employee Wellness Program
Drug & Alcohol screening	Assessment	Health Promotion
Chest X-Ray	Functional Capacity Evaluation	Health Surveillance
ECG	Exit Medical	Travel Medicine
Functional Performance Assessment	Other	Other
Functional Capacity Evaluation		
Commercial Drivers Assessment		
Do you require 4cRisk to provide the assessment paperwork? Y N		



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Terms and Conditions

1. All appointments will be confirmed in writing using the "Pre-employment Medical Form" .
2. Payment is due within 14 days from the date of invoice unless alternative terms are agreed upon by 4cRisk Network in writing.
3. 4cRisk Network or nominated representatives, reserves the right to actively pursue collection of outstanding amounts. Any costs associated with this will be passed on to the account holder.
4. Non-attendance fees are charged at the discretion of Management.

I/We have read the Terms and conditions and agree to abide by them.

Authorised Person 1 Name:	Position:
Signature:	Date:
Authorised Person 2 Name:	Position:
Signature:	Date:

Please fax to Medical Appointments on 07 3839 1557