Employer *Registration Card*

Company Name

Street Address

Mailing Address

City State Zip

( ) Telephone

Type of Business

Responsible Party/Title

Contact Person/Title

Dates of Open Enrollment

Number of Employees # of Shifts

Workers Compensation Carrier

Policy Number

Expiration Date

Address

City State Zip

( ) Telephone

Special Instructions

Authorized Signature Date

VALLEY OCC-MEDICAL CENTER

1009 Glenoaks Blvd. San Fernando, CA 91340

Tel. (818) 361-3369