Drug Screening Account Information

Date: Company Name:

Main Contact Name: Billing Contact: ☐ same

Physical Address

_____

_____
(City) (ST) (Zip)

MailingAddress ☐ same

_____

_____
(City) (ST) (Zip)

Billing Address ☐ same

_____

_____
(City) (ST) (Zip)

Main Phone #: ( ) Alt Phone #: ( ) Fax #: ( )

Email: How many employees do you have:

Person(s) authorized to receive drug screen results and preferred method: **(Please circle one and provide number or email)**

1. _____ fax/email: _____
2. _____ fax/email: _____
3. _____ fax/email: _____

Type of Business: (i.e. retail, construction, hospitality, banking, etc.)

Do you currently have a Drug Free Workplace Policy? Yes ☐ No ☐

Do you need a Drug Free Workplace Written Policy: Yes ☐ No ☐

If Yes, Disciplinary options: Immediate Termination ☐ 2nd Chance ☐

Would you like Random Testing? Yes ☐ No ☐ Need more Info ☐

If Yes, Monthly ☐ **or** Quarterly ☐,

If Yes, What % of workforce (per year) or fixed #: _____

Do you want to test all of your existing employees after initial 60 days of start of the DFW program? Yes ☐ No ☐

Do you have DOT Regulated employees?

No ☐ Yes ☐ **(please indicate mode below)**

☐ FMCSA ☐ FRA

☐ PHMSA ☐ FTA

☐ USCG ☐ FAA

Workers Comp Insurance Information: Policy #: _____

Name and Address of Insurance Co: _____

_____
(Address)

_____
(City) (ST) (Zip) (Phone)

Agent Name: Phone: Fax:

Are you currently Drug Screening? Yes ☐ No ☐ Under what circumstances:

☐ Pre-Employment ☐ Random ☐ Post Accident ☐ Reasonable Suspicion ☐ Other _____

Lab Used: MRO Name: Total Cost: $

How did you hear about us: [please check one]

Dept of Labor website _____

Yellow Pages _____

Mail Out _____

Insurance Agent* _____

Current Client* _____

Search Engine* _____

Conference* _____

Other A Matter of Fact

* please list name _____