



DOT DRUG & ALCOHOL TURNKEY COMPLIANCE SOLUTION

DOT COMPLIANCE PACKAGE:

<ul style="list-style-type: none"> • Drug Testing Collection – local facilities • Referrals to Substance Abuse Professional • Membership in DOT random testing consortium or individual selections • Random selections and notifications - quarterly • Toll free consultation and administrative support • Blind sample submissions • Previous Employer Drug/Alcohol verification forms • Employee Education and Supervisor Training Materials 	<ul style="list-style-type: none"> • Policy manual with all policies, forms and required up to date regulations • Post accident collection site identification, set-up and management • Toll free 24 hour Post Accident number for emergency testing • Post accident testing kits • Pre-printed customized chain of custody forms for each client • Drug testing to include specimen collection, initial lab test and GC/MS confirmation • Certified, full time, MRO reporting of results – via fax, or e-mail • On Going Consultation • Turnkey Compliance
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Fees for this service are as follows:

Initial Start up fee - \$250.00 Per Drug or Alcohol Test - \$45.00

Annual Renewal for Consortium Membership: Annual Fee - \$75.00, plus \$10.00 per DOT regulated employee.


Testing Fee Includes: 5 panel DOT drug screen, collection of specimen, lab testing with confirmation, MRO reporting, MIS reports when required and/or requested, certified random selections, blind sample submissions – all DOT approved.

These services will keep you in compliance with the DOT drug and alcohol testing regulations – 49 CFR Part 40 and the regulations of your operating administration.

This is a complete turnkey package, which we provide everything you will need.

Please visit our web site for additional information on our company
WWW.DRUGTESTINGUSA.COM

IMPORTANT INFORMATION TO SET UP ACCOUNT – PLEASE FAX TO 321 953 6545

Date: _____		Company Name: _____	
Main Contact Name: _____		Billing Contact: <input type="checkbox"/> same	
Mailing Address _____ _____ <small>(City) (ST) (Zip)</small>	Physical Address <input type="checkbox"/> same _____ _____ <small>(City) (ST) (Zip)</small>	Billing Address <input type="checkbox"/> same _____ _____ <small>(City) (ST) (Zip)</small>	
Main Phone #: ()	Alt Phone #: ()	Fax #: ()	
Email: _____			#of employees: _____
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, etc.)			
Do you currently have a Drug Free Workplace Policy? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you need a Drug Free Workplace Written Policy: Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have DOT Regulated employees?	
If Yes, Disciplinary options: Immediate Termination <input type="checkbox"/> 2 nd Chance <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/> (please indicate mode below)	
Would you like Random Testing? Yes <input type="checkbox"/> No <input type="checkbox"/> Need more Info <input type="checkbox"/>		<input type="checkbox"/> FMCSA <input type="checkbox"/> FRA	
If Yes, Monthly <input type="checkbox"/> or Quarterly <input type="checkbox"/>		<input type="checkbox"/> PHMSA <input type="checkbox"/> FTA	
What % of workforce (per year) or fixed #: _____		<input type="checkbox"/> USCG <input type="checkbox"/> FAA	
Do you want to test all of your existing employees after initial 60 days of start of the DFW program? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Workers Comp Insurance Information: Policy #: _____			
Name and Address of Insurance Co: _____			
_____ <small>(Address)</small>			
_____ <small>(City) (ST) (Zip) (Phone)</small>			
Agent Name: _____		Phone: _____	Fax: _____
Are you currently Drug Screening? Yes <input type="checkbox"/> No <input type="checkbox"/> Under what circumstances:			
<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> 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 _____ * please list name _____		 FLORIDA DRUG SCREENING WWW.DRUGTESTINGUSA.COM 2191 Julian Ave, Suite 2 / Palm Bay, Florida 32905 888-441-4599 / 321-953-6545 fax info@drugtestingusa.com	
		Website	