


Client Set-Up Sheet
Please Fax Back to 321-872-0460

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 #: () () ()		Fax #: () () ()		Alt. Phone #: () () ()	
Email:			Projected # tests per year:		
How would you like to receive test results: Web Site <input type="checkbox"/> E-mail <input type="checkbox"/> Secure Fax <input type="checkbox"/>					
List those authorized to receive drug test results; include e-mail and/or fax, depending on method chosen above.					
1. _____		Fax/E-mail: _____			
2. _____		Fax/E-mail: _____			
3. _____		Fax/E-mail: _____			
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 request from us a Drug Free Workplace Written Policy: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Disciplinary options: Immediate Termination <input type="checkbox"/> 2nd Chance <input type="checkbox"/>				Do you have DOT Regulated employees? No <input type="checkbox"/> Yes <input type="checkbox"/> (if yes, please indicate mode below) <input type="checkbox"/> FMCSA <input type="checkbox"/> FRA <input type="checkbox"/> PHMSA <input type="checkbox"/> FTA <input type="checkbox"/> USCG <input type="checkbox"/> FAA	
Would you like Random Testing? Yes <input type="checkbox"/> No <input type="checkbox"/> Need more Info <input type="checkbox"/> If Yes, Monthly <input type="checkbox"/> or Quarterly <input type="checkbox"/> , Date to Start Random Testing: _____ What % of workforce do you want tested (per year) or fixed #:					
Do you want to test all of your existing employees after initial 60 days of start of DFW program? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Workers Comp Insurance Information (required only if applying for a workers compensation discount): Company Name _____ Policy #: _____					
Address _____		City _____		State _____	Zip code _____
Phone _____		Fax _____		Contact _____	
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 _____					
How did you hear about us: [please check one] Dept of Labor website _____ Yellow Pages _____ Mail Out _____ Insurance Agent* _____ Current Client* _____ Search Engine* _____ Conference/Trade Show* _____ Other _____ *please list name _____			 FLORIDA DRUG SCREENING WWW.DRUGTESTINGUSA.COM 2191 Julian Ave. Palm Bay, Florida 32905 888-441-4599 321-872-0460 fax info@drugtestingusa.com		
			<i>Rep: Web Site</i>		