


**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: _____		<b>Projected # tests per year:</b> _____	
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"/>		Do you have DOT Regulated employees? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If Yes, Disciplinary options: Immediate Termination <input type="checkbox"/> 2 <sup>nd</sup> Chance <input type="checkbox"/>		<b>(if yes, please indicate mode below)</b>	
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"/> , Date to Start Random Testing: _____		<input type="checkbox"/> PHMSA <input type="checkbox"/> FTA	
What % of workforce do you want tested (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 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 _____			
<b>How did you hear about us: [please check one]</b> Dept of Labor website _____ Yellow Pages _____ Mail Out _____ Insurance Agent* _____ Current Client* _____ Search Engine* _____ Conference/Trade Show* _____ Other _____ *please list name _____		 780 S. Apollo Blvd. Melbourne, Florida 32901 888-441-4599 321-872-0460 fax <a href="mailto:info@drugtestingusa.com">info@drugtestingusa.com</a>	
		Rep: Web Site	