

Company Information

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Email: _____

Phone: _____ Fax: _____

Billing Contact: _____

Email: _____

Phone: _____ Fax: _____

Number of employees: _____

Send bills to: Company or Workers Compensation Insurance Company

Work Comp Insurance Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Type of Services Requested

Please select all services needed below

- Workers Compensation DOT Exams
 Pre Placement Exams Breath Alcohol Testing

Specific Testing not listed above: _____

- Urine Drug Screen Testing
 Rapid or Standard or Collection Only
 5 Panel Non DOT Urine Drug Screen
 5 Panel DOT Urine Drug Screen
 10 Panel Non DOT Urine Drug Screen

Results communicated via: Mail Phone Fax

Results Contact Name: _____

Contact Phone: _____ Contact Fax: _____