CLIENT PROFILE FORM

COMPANY NAME:_____Date:_____

Main Contact Person:_____ Alternate Contact:_____

Phone No._____ Alt.Phone No._____ Fax._____

Email:_____

Physical Address: _____

Mailing Address:_____
(If different from physical address)

Billing Address:_____
(If different from above)

EMPLOYEE TESTING PROGRAM DETAILS:

How would you like to receive test results? _____E-mail _____Postal Mail _____Phone

List those authorized to receive test results; include e-mail and /or phone depending on method chosen above.

1._____Email/Postal Mail_____

2._____Email/Postal Mail_____

3._____Email/Postal Mail_____

Type of Business:_____

Do you currently have a Drug Free Work Place Policy? _____Yes _____No

Under what circumstances do you currently drug test? Pre- employment_____ Random____
Post Accident _____ Reasonable Suspicion_____Other_____

If yes, Disciplinary options: Immediate Termination____ 2nd Chance_____ SAP Reentry _____

Do you have a Random Testing Program?_____ If yes, monthly?____ quarterly_____

What percentage of workforce do you test per year or fixed number?_____

Do you have DOT Regulated employees? _____Yes _____No

In the event of a toxicology test where our office is reporting a positive test result, would you like for the employee to have access to an Employee Assistance Program (EAP)? _____Yes _____No

Do you require a Pre- employment physical of employees? Yes_____ No_____

Please check any service item below your employees may require:

Audiogram Testing_____

Breathe Alcohol Testing_____

Employee Wellness Screenings_____

DOT Physicals_____

Respirator Fit Testing_____ OSHA Medical Health Questionnaire / Clearance_____

Toxicology Test_____

Mobile Testing Services:
How likely would you utilize our mobile testing service for toxicology, respirator fit testing or audiology testing in your
workplace?_____
_____
_____

How did you hear about us: _____

Company Profile Completed By:_____

Title_____