FORENSIC
DRUG TESTING SERVICES

2019 SAMPLE
POLICY REQUEST FORM

Please, complete and submit this form for your ***FREE COPY !***

PRIMARY D.E.R.: Authorized Recipient of Test Results:

OFFICE Phone: CELL: *Fax:*

Confidential E-Mail for Results (Required):

Desired Password or Phrase: (Required):

Physical Address:

Mailing Address:
☐ *Same as Physical, above.*

ALTERNATE D.E.R.: Authorized Recipient of Test Results:

OFFICE Phone: CELL: *Fax:*

Confidential E-Mail for Results (Required):

Desired Password or Phrase (Required):

☐ *(Check Box, if same as Primary DER)* Physical Address:

☐ *(Check Box, if same as Primary DER)* Mailing Address:

BILLING CONTACT: ☐ ***Invoice me*** ** 30 day Net, with agreement.* ☐ *Set-Up Auto-Pay* **Complete section below.* ☐ *Paying COD,* ** Retail rates apply.*

☐ *(Check Box, if same as Primary DER)*

Full Name: Phone: *Fax:*

E-MAIL:

Billing Address for Invoices *(City, State & Zip):*

I, the *Designated Employer Representative (Primary D.E.R.),* for the above listed Company, hereby give our directive and authorization for Forensic Drug Testing Services Inc. to receive all our drug & alcohol test results and information directly from the testing lab & MRO and process those results according to the above listed directive. Furthermore, we give Forensic DTS, Inc. and its employees our authorization to access our Commercial Driver's License Drug and Alcohol Clearinghouse Database, as our authorized agent of record.

- ***This directive supersedes all previous directives.*** -

COMPANY NAME: Date:

PREPARER'S NAME: Signature:

AUTO-PAY Authorization: *(Please bill this card for all open Invoices - optional)*

Card Number (Account #) ***Card Expires:*** ***Card Code:***

Checking Acct #: ***Routing #:*** ***Check #:***

Statement Address & Zip:

Account Holder's Authorized Signature: ***Approval Date:***

73-700 Dinah Shore Drive, Suite 206, Palm Desert, CA 92211

Updated: 03/27/2019-KO