



CLIENT PROTOCOL

Please, tell us how you'd like your Drug Prevention & Testing Program managed by FDTSI.

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):

Physical Address:

Mailing Address: Same as Physical, above.

BILLING CONTACT:

Invoice me * 30 day Net, with agreement.

Set-Up Auto-Pay *Complete section below.

Paying COD, * Retail rates apply.

Same as Primary D.E.R., listed above.

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: