NEW CLIENT AUTHORIZATION AND SERVICE AGREEMENT

Company Name: ____

Mailing address: ____

Company Phone Number: ______________ **Fax Number**: ______________ **Email:** ______________

Primary Contact Person: ____

If physical address is different from mailing address, please note below:

____

Billing Contact: ______________________ **Billing Address**: ______________________

Phone Number: ______________ **Fax Number**: ______________ **Email:** ______________

CLIENT AUTHORIZATION FOR RELEASE OF TEST RESULTS

______________________ Primary Contact Name) hereby authorizes to disclose test results for specimens

by employees/applicants of ______________________ (Company Name) personnel:

Primary Designated Employee Representative (DER):

Name: ____

Phone Number: ______________ Fax Number: ______________ Email: ______________

If primary DER is unavailable, provide contact information for alternate(s) DER:

Alternate Secondary DER:

Name: ____

Phone Number: ______________ Fax Number: ______________ Email: ______________

Alternate Third DER:

Name: ____

Phone Number: ______________ Fax Number: ______________ Email: ______________

After-Hours DER Contacts (Monday-Friday):

Name:____

Phone Number: ________________ Fax Number: ________________ Email: ________________________

After-Hours DER Contacts (Saturday-Sunday):

Name:____

Phone Number: ________________ Fax Number: ________________ Email: ________________________

Emergency Contact If After-Hours DER Contacts Are Unavailable:

Name:____

Phone Number: ________________ Fax Number: ________________ Email: ________________________

Would you like client portal access, if available, for the services your company requires? YES NO

Select Account Service:

____ **Full service:** *we* will provide all testing supplies, chain of custody forms (CCF), and medical review officer/physician for non-negative results. **ADD WORKERS' COMPENSATION SERVICES** YES NO

____ **Collection only:** *you* will provide all testing supplies, chain of custody forms (CCF), and have your own medical review officer/physician for non-negative drug tests or medical results. **ADD WORKERS' COMPENSATION SERVICES** YES NO

DOT Companies:

Would you like us to manage your random pulls? (IF SO, ATTACH EMPLOYEE LIST) YES NO

Would you like to sign up for our DOT Consortium Program for random pool testing? YES NO

(This program is designed to save money and provide an efficient solution for random drug testing as required by DOT, especially for smaller companies. Fees apply for this service.)

If so, how many employees are in your company? _________

Signature:____

Title:____

Print Name:____________________________Date:__________________

DRUG AND ALCOHOL TESTS:

Test		
Breath Alcohol DOT	YES	NO
Breath Alcohol Non-DOT	YES	NO
Drug Test: DOT Split (Lab-Based)	YES	NO
Drug Test: DOT (collect only)	YES	NO
Drug Test: Hair (collect only)	YES	NO
Drug Test: 5 Panel Rapid	YES	NO
Drug Test: 10 Panel Rapid	YES	NO
Drug Test: Non-DOT (Lab Based)	YES	NO
Drug Test: Lab Confirmation if Results Non-Negative	YES	NO

PHYSICALS:

Physical		
Annual/Basic Physical	YES	NO
Respiratory Physical (incl: Spirometry PFT, Respirator Fit Test. And OSHA Questionnaire)	YES	NO
Employment Physical: DOT	YES	NO
Employment Physical: Fit for Hire	YES	NO
Employment Physical: Post Incident	YES	NO
Employment Physical: Return to Duty	YES	NO

LABS:

Lab			Lab		
CBC with Diff	YES	NO	Cholesterol Lipid Panel	YES	NO
CMP Comp Metabolic Panel	YES	NO	CRP C-Reactive Protein	YES	NO
HCG Qualitative	YES	NO	HCG Quantitative	YES	NO
Hemoglobin (Hb) A1C	YES	NO	Hepatitis B Antibody Titer	YES	NO
Hepatitis C Titer	YES	NO	Hepatic Function Panel	YES	NO
HIV	YES	NO	Lead & Protoporphyrin	YES	NO
Mumps Titer	YES	NO	PSA Prostate-Specific	YES	NO
Rapid Urinalysis	YES	NO	Rubella Titer	YES	NO
Rubeola Titer	YES	NO	Two Step TB Test	YES	NO
TB Test (PPD)	YES	NO			

VACCINATIONS:

Influenza (Flu)	YES	NO	Hepatitis A	YES	NO
Hepatitis B	YES	NO	Meningococcal	YES	NO
MMR	YES	NO	Poliovirus	YES	NO
Tdap	YES	NO	TwinRix (Hep A & Hep B)	YES	NO
Typhoid	YES	NO	Varicella	YES	NO
COVID-19	YES	NO			

OCCUPATIONAL HEALTH:

EKG	YES	NO	Respiratory Fit Test	YES	NO
GFT Spirometry	YES	NO			
COVID-19 Antigen Active	YES	NO	COVID-19 Antibody	YES	NO

AFTER HOURS:

5pm – 12a (Monday-Friday)	YES	NO	12am – 8am (Monday-Friday)	YES	NO
Saturday/Sunday (8am – 12am)	YES	NO	Saturday/Sunday (12am-8am)	YES	NO
Holidays	YES	NO	Wait Time	YES	NO
Onsite Option	YES	NO			

State Drug Testing & Occupational Health, Inc. shall be permitted to send test results by telephone, fax or client portal.
I understand that State Drug Testing & Occupational Health, Inc. ***will not release test results or other confidential information to anyone other than the listed representatives.***

______________________________ (Company Name) agrees to hold State Drug Testing & Occupational Health, Inc. or any of its agents harmless from any action that may arise out of such test results being divulged to any of the individuals listed above. I agree to contact State Drug Testing & Occupational Health, Inc. if there are any changes regarding this authorization.

Signature of Company Representative: ______________________________

Print Name: ______________________________

Date: ______________________________

PLEASE REMEMBER DONORS MUST HAVE PHOTO ID (DRIVER'S LICENSE, STATE ID, ETC.)