STATE DRUG TESTING
& OCCUPATIONAL HEALTH, INC.

24 W CHATHAM CT, SAVANNAH, GA 31408
PH: 912-446-1777 · FAX: 912-250-6046

NEW CLIENT AUTHORIZATION AND SERVICE AGREEMENT

Company Name & Mailing address:

____

____

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

____

Alcohol Testing: (select any services applicable to your company):

____ Breath Alcohol (DOT) ____ Breath Alcohol (non-DOT)

Would you like to automatically add a rapid drug screen if we are conducting a breath alcohol test? **( ) YES ( ) NO**

Do you want your positive threshold for breath alcohol to be set at the federal guidelines of 0.02? **( ) YES ( ) NO**

Drug Profile Services: (select any services applicable to your company):

____ DOT/SAMHSA split test panel ____ Non-DOT lab-based test

____ Hair Test ____ Oral fluid test

____ POCT/Rapid 10 Panel Test (THC, Cocaine, Opiates, Amphetamine, Methamphetamine, PCP, benzodiazepines, barbiturates, methadone, oxycodone)

For POCT/Rapid services:

If your employee/applicant tests non-negative, do you want to send to a lab for confirmation? **( ) YES ( ) NO**

Select Account Service:

____ **Full service:***we* will provide all testing supplies, chain of command forms (CCF), and medical review officer/physician for non-negative results.

____ **Collection only**: *you* will provide all testing supplies, chain of command forms (CCF), and have your own medical review officer/physician for non-negative drug tests or medical results.

DOT Companies:

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: ____________

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CLIENT AUTHORIZATION FOR RELEASE OF TEST RESULTS

______________________________ (Name) hereby authorizes to disclose test results for specimens by

employees/applicants of ______________________________ (company name) personnel:

Primary Designated Employee Representative (DER):

Name: ______________________________

(phone) ______________ (secure fax) ______________

Email: ______________________________

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

Alternate DER printed name: ______________ (phone)______________

Email: ______________________________ (secure fax)______________

Alternate DER: ______________________________ (phone) ______________

Email: ______________________________ (secure fax)______________

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

After-Hours DER Contacts (Monday-Friday):
Name: ______________________________

(phone) ______________ (secure fax) ______________

Email: ______________________________

After-Hours DER Contacts (Saturday-Sunday) :
Name: ______________________________

(phone) ______________ (secure fax) ______________

Email: ______________________________

Emergency Contact if After-Hours DER Contacts are unavailable: ______________________________

____

Billing Contact: ______________ (phone) ______________

Email: ______________ (billing address) ______________________________

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 representatives listed above.***

______________________________ (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.)