



# DRUG FREE WORKPLACE PROGRAM

OUTLINE OF SERVICES AND BENEFITS

<b><i>SERVICES</i></b>	<b><i>BENEFITS</i></b>
<ul style="list-style-type: none"> <li>• 60 Day Notice of Intent to Test</li> <li>• Customized written policy</li> <li>• Employee Education Materials</li> <li>• Supervisor Training Materials</li> <li>• Access to Employee Assistance Program (EAP)</li> <li>• Drug testing at local facilities - collection, lab analysis, and MRO review/reporting</li> <li>• Random Testing Program Management if requested</li> <li>• Policy Changes and updates</li> <li>• On-going consultation</li> </ul>	<ul style="list-style-type: none"> <li>• Professional management of your drug/alcohol testing program</li> <li>• Peace of mind</li> <li>• Personalized Customer Service with exceptional quality</li> <li>• Excellence in turnaround time</li> <li>• Drug Free Employees</li> <li>• Decreased turnover, absenteeism, and tardiness</li> <li>• Increased employee morale and productivity</li> <li>• Workers compensation insurance incentives</li> <li>• Fewer workplace accidents</li> <li>• Nationwide service</li> <li>• Industry Expertise</li> <li>• Competitive Pricing</li> <li>• Legal Compliance/Defensibility</li> </ul>

Includes filing with workers' comp carrier for 5% discount on annual premium

## DISCOUNTS FOR HIGH VOLUME ACCOUNTS

Requirements include testing of all new employees; existing employees are only tested after an accident, or under reasonable suspicion.


\*In remote areas there may be additional pass through charges when a clinic is needed for specimen collection out of network.

***Any questions please call 1.888.441.4599***

To get started just fax in the attached Client Setup sheet to 321.872.0460



## ACCOUNT SET-UP FORM

Date: _____		Company Name: _____	
Main Contact Name: _____		Billing Contact: <input type="checkbox"/> same	
Mailing Address _____ _____ _____ (City) _____ (ST) _____ (Zip) _____	Physical Address <input type="checkbox"/> same _____ _____ _____ (City) _____ (ST) _____ (Zip) _____	Billing Address <input type="checkbox"/> same _____ _____ _____ (City) _____ (ST) _____ (Zip) _____	
Main Phone #: (    ) _____	Fax #: (    ) _____	Alt. Phone #: (    ) _____	
Email: _____		<b>Projected # tests per year:</b> _____	
List those authorized to receive drug test results; include e-mail and/or fax, depending on method chosen above.			
1. _____	E-mail: _____		
2. _____	E-mail: _____		
3. _____	E-mail: _____		
Type of Business: _____ (i.e. retail, construction, etc.)			
Do you currently have a Drug Free Workplace Policy? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you request from us a Drug Free Workplace Written Policy: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Disciplinary options: Immediate Termination <input type="checkbox"/> 2 <sup>nd</sup> Chance <input type="checkbox"/>		Do you have DOT Regulated employees? No <input type="checkbox"/> Yes <input type="checkbox"/> <b>(if yes, please indicate mode below)</b> <input type="checkbox"/> FMCSA <input type="checkbox"/> FRA <input type="checkbox"/> PHMSA <input type="checkbox"/> FTA <input type="checkbox"/> USCG <input type="checkbox"/> FAA	
Would you like Random Testing? Yes <input type="checkbox"/> No <input type="checkbox"/> Need more Info <input type="checkbox"/> If Yes, Monthly <input type="checkbox"/> or Quarterly <input type="checkbox"/> , Date to Start Random Testing: _____ What % of workforce do you want tested (per year) or fixed #: _____			
Do you want to test all of your existing employees after initial 60 days of start of DFW program? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Workers Comp Insurance Information (required only if applying for a worker's compensation discount): Company Name _____ Policy #: _____			
Address _____		City _____	State _____ Zip code _____
Phone _____		Fax _____	Contact _____
Are you currently Drug Screening? Yes <input type="checkbox"/> No <input type="checkbox"/> Under what circumstances: <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Other _____			
<b>How did you hear about us: [please check one]</b> Dept of Labor website _____ Yellow Pages _____ Mail Out _____ Insurance Agent* _____ Current Client* _____ Search Engine* _____ Conference/Trade Show* _____ Other _____ *please list name _____		 <b>FLORIDA DRUG SCREENING</b> <a href="http://WWW.DRUGTESTINGUSA.COM">WWW.DRUGTESTINGUSA.COM</a> 2191 Julian Ave, Suite 2 Palm Bay, Florida 32905 888-441-4599 321-872-0460 fax <a href="mailto:info@drugtestingusa.com">info@drugtestingusa.com</a>	
		<i>Web Site</i>	

