CAROLINA TESTING

When Results Matter Most…
LEAVE THE TESTING TO US.
www.CarolinaTesting.com

NEW ACCOUNT SERVICES SET UP FORM

COMPANY NAME: _____

DESIGNATED EMPLOYER REPRESENTATIVE (DER):
The primary contact(s) who handles all testing related matters and receives completed Chain of Custody Forms (CCFs) & test results.

Main Contact: _____ **Phone:** (____)____-_____ **Emergency Phone:** (____)____-_____

Alternate Contact: _____ **Phone:** (____)____-_____ **Emergency Phone:** (____)____-_____

Physical Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Main Email: _____ **Alternate Email:** _____

Send Employer Copy of CCFs & Results Via: ☐ Secure Online Portal ☐ Email ☐ Mail ☐ Fax: (____)____-_____

DOT REGULATED COMPANIES ONLY:
AGENCY: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG **DOT #:** _____

ACCOUNT SERVICES REQUESTED:

DRUG TESTING

☐ **URINE:** **DOT:** ☐ DOT Drug Test Panel

NON-DOT: ☐ 5 Panel ☐ 10 Panel ☐ Other:_____
☐ 5 Panel Rapid w/ Lab Confirmation ☐ 10 Panel Rapid w/ Lab Confirmation

☐ **SALIVA:** ☐ **HAIR:**
☐ 6 Panel ☐ 9 Panel ☐ 5 Panel + Exp Opiates ☐ 10 Panel

BREATH ALCOHOL TESTING
☐ DOT ☐ NON-DOT

RANDOM PROGRAM MANAGEMENT (Complete Random Management Agreement Form)
☐ DOT ☐ NON-DOT

OCCUPATIONAL HEALTH
☐ DOT Physicals ☐ Pre/Post Employment Physicals ☐ Respirator Fit Testing

BACKGROUND CHECKS
☐ National Background Check ☐ National + Motor Vehicle Record (MVR) ☐ MVR Only

OFFICE USE ONLY
SYSTEM SETUP: ☐ i3screen ☐ eScreen ☐ NCS
PROVIDERS): ☐ Quest ☐ LabCorp ☐ Abbott ☐ Nexscreen ☐ Expertox ☐ Premier ☐ WHSS

NEW ACCOUNT BILLING & PAYMENT SET UP

COMPANY NAME: _____

ACCOUNTS PAYABLE REPRESENTATIVE:
The primary contact who receives, authorizes and manages payables for the company.

Name: _____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone: (____)_____-_____ **Email Address:** _____

Preferred Invoice Delivery Via: ☐ Email ☐ Mail ☐ Fax: (____) _____-_____

☐ **AUTOMATIC CREDIT CARD PAYMENT**
Payments processed by the 5th of the month for the previous month's transactions.

By submitting and signing this document, I attest that I am an authorized user of the credit card provided for payment of services provided by Carolina Drug & Alcohol Testing Services, LLC (CDATS) or its assigns. I authorize CDATS to charge this designated credit card for the total amount due for services rendered on this account within 5 days of invoice generation. I agree to notify CDATS in writing of any changes to my account information or termination of this authorization at least 15 days prior to the next billing date. Unpaid invoices are subject to the terms & conditions of this agreement.

Card Type: ☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX

Cardholder Name: _____

Account Number: _____

Exp. Date: ____ /____ Security Code: _____ Billing Zip Code: _____

☐ **NET 30 DAYS BILLING**
Total Invoice amount is due and payable within 30 days of the invoice date.

TERMS & CONDITIONS:
Payments not received within 45 days of invoice date will incur a $25.00 late fee plus interest of 18% per annum until paid in full. Payments not received within 60 days of invoice date will be subject to service suspension and collection activities. All collection and legal fees incurred in an attempt to collect on invoices will be added to the account in addition to ongoing finance charges.

I understand and agree to the billing terms & conditions described above.

Authorized Signature: _____ Date: _____

Printed Name: _____ Title: _____