

NEW ACCOUNT SERVICES SET UP FORM

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: (State: Zip: Alternate Contact: 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 #: DOT REGULATED COMPANIES ONLY: AGENCY: FMCSA FAA FRA FTA PHMSA USCG DOT #: DOT REGULATED COMPANIES ONLY: AGCCOUNT SERVICES REQUESTED: DRUG TESTING URINE: DOT: DOT Drug Test Panel NON-DOT: 5 Panel 10 Panel Other: G Fanel 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 CCCUPATIONAL HEALTH DOT NON-DOT CCCUPATIONAL 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: Bacreen eScreen NCS		COMPANY N	AME:	
Alternate Contact: 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: Alternate Email: Send Employer Copy of CCFs & Results Via: Secure Online Portal Email: Alternate Email: Send Employer Copy of CCFs & Results Via: Secure Online Portal Email: Alternate Email: Secure Online Portal DOT REGULATED COMPANIES ONLY: AGENCY: FRA FRA FTA PHMSA USCG DOT #: ACCOUNT SERVICES REQUESTED: DRUG TESTING URINE: DOT: DOT: DOT DOT prug Test Panel Image: S Panel Image: Image: Image: Imag				hain of Custody Forms (CCFs) & test results.
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Mailing Address:	Alternate Contact:		Phone: ()	Emergency Phone: ()
Main Email:	Physical Address:		City:	State: Zip:
Send Employer Copy of CCF's & Results Via: Secure Online Portal Imail	Mailing Address:		City:	State: Zip:
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PROVIDERS): Quest LabCorp Abbott Nexscreen Expertox Premier WHSS				Expertox



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:______ State:_____ Zip:_____ City:______ 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: