



Smart Testing Services

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DRUG AND ALCOHOL TESTING ACCOUNT OPENING FORM

Company: _____ DOT #: _____

Billing Address: _____ City: _____

Province: _____ Postal Code: _____

Ph: _____ Fax: _____ Email: _____

Contact will be the main contact with full access rights to all information and results concerning drug and/or alcohol tests.

Contact Name: _____ Title _____

Ph: _____ Fax: _____ Email: _____

Additional Contacts (To be used if you require additional contacts have access to this account.)

Name: _____ Title _____

Ph: _____ Fax: _____ Email: _____

Do you currently, or have you had a DOT compliant random drug testing program in the last 30 days? Yes No

(If Yes Please provide the information for all drivers' participating in this drug testing program.)

Number of Drivers: _____ Random Program Start date: _____

Terms and Conditions:

I/We acknowledge the receipt of price lists and the list of my responsibilities as an Employer as per US DOT REGULATIONS.
I/We understand that upon signing this form Company is liable for monthly Random program Charges.
I/We undertake to update the employee list in writing to Smart Testing Services.
I/We understand that if our account is Outstanding for 90 days or more, our Account will be closed and Smart Testing Services will not be liable for any claims OR damages thereof.

Company Representative's Name

Signature

Date (mm/dd/yy)