



The Drug Testing Alliance Membership Application

Application Date: _____

Name of Company:					
Owner:	First Name		Last Name		
Street	City		State	Zip	
Contact Person:	First Name		Last Name		
Company Phone Number	Contact Phone Number		Alternative Phone		
DOT Regulated Employees?	Yes	No	How Many:	Motor Vehicle Reports:	Yes No
Post Accident:	Yes	No		Reasonable Suspicion:	Yes No

Business Type:	Number of Employees:	Employee Types:	I	II	III	IV	V
----------------	----------------------	-----------------	---	----	-----	----	---

Number of Policies Needed:	Number of Decals:
----------------------------	-------------------

List All Owners/Partners/Employees:			Results of:		
First Name	Last Name	SSN	Background Search	Initial Drug Test	Breath Alcohol

Membership Date:
Member Number:
Invoice Date:
Invoice Amount:
Method of Payment:

The Drug Testing Alliance is a program developed for OnSITE Drug Testing & Consulting clients with established drug testing programs or are currently establishing a drug testing program. All prospective member programs will include having a background search, a 10 Panel oral saliva drug test and Breath Alcohol test conducted for the owner, partner(s) and all employees once a year and each person is to be included in a random testing consortium. It is understood if a test is confirmed positive, or background search does not meet the criteria outlined by the Alliance, the membership may be denied. Acting on behalf of the applicant, I agree, said company is responsible for payment of searches and tests conducted regardless of the outcome.

X _____

Print Name: _____ Title: _____