

Client Information
Allied Compliance Services®
 1-800-411-6906 Fax (806) 748-7096

Top portion to be completed by client and returned to ACS:

Date: _____			County: _____			Co. DOT No. _____		
Company Name: _____ <small>Legal Name</small>								
Mailing Address: _____				Physical Address: _____				
Phone: _____			Fax: _____			E-mail: _____		
Designated Employee Representative (DER) (Please give a second name) These persons can receive results:								
1. _____			2. _____			3. _____		
Owner Name: _____				Highest Official: _____				
Billing Inquiries: _____				Referred by: _____				

↓ *For ACS Office Use Only* ↓

Type of Testing

- ___ Drug / Lab _5 panel _10 panel
- ___ Urine DSC / Saliva DS
- ___ Alcohol
- ___ Hair Analysis
- ___ DNA
- ___ Pre-empl. Only
- ___ Testing Only (our lab)
- ___ Collection Only (their lab)
- ___ Co. Form / ACS Form
- Collections
 - ___ In Office / On-site / Clinic
 - Clinic Name: _____
- Test Results
 - ___ Called / Mailed / Faxed
 - ___ Fax Secure: Yes No

Account Information

- ___ DOT Reg. / Non-reg. / TDLR
- ___ FMSCA HAZ/MAT FAA FTA FRA PHMSPA
- ___ ACS Policy / Co. Policy
- # of Employees Tested _____
- ___ DOT ___ Non-DOT ___ TDLR
- Random Testing: Qtrly / Monthly / Other
 - ___ Private
 - ___ Consortium
- Consortium Name: _____
- Physicals: Yes No
- Previous Testing: Yes No
- ___ Acpt. Agreement
- Location: _____
- Directions to Company:**

Renewal Date: ___/___/___

- ___ QBooks ___/___/___
- ___ Access ___/___/___
- ___ Drug Pak ___/___/___
- ___ Consort. Assigned ___/___/___
- ___ Fee Schedule Attached Yes ___ No ___
- ___ Fax List ___/___/___

Protocol Notes: