



Drug Screening Setup Form
C/TPA SUB-ACCOUNT SET UP

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Contact Person: _____

Alternate Contact Person: _____

Type of testing being performed: DOT NON-DOT DFWP/HRS Other

Special Instructions/Comments: _____

Authorized by: _____ Title: _____ Date: _____

PLEASE FAX TO 888-763-7366

FOR OFFICE USE ONLY

Global Information Network REPORT RESULTS VIA:

Fax to # _____ Email to _____

Web Reporting 4 digit pin # _____