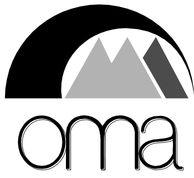



**Occupational Medicine Associates**

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# Client Information

Company Name:__________________________________________________

Address______________________________________________________

City, State & Zip________________________________________________

Phone_______________________________________________________

Email Address __________________________________________________

***PLEASE WRITE YOUR E-MAIL ADDRESS AS CLEAR AND LEDGABLE AS POSSIBLE***

Billing Address If different:____________________________________________

Fax Number________________________________ Do we need to call first? Y N

Primary Contact________________________ Secondary Contact____________________

Phone____________________________ Phone_______________________________

**Report Results by (check all that apply)**

Email_________ Fax_________ Mail_________ Phone & Mail_________

Random pool selection options Monthly____ Quarterly____ Percentage (if non-DOT)______

***Please note:*** All DOT testing is 50% of the pool drug testing per year and 10% alcohol per year

Independent testing________ or Consortium________

Number of DOT employees________ Number of Non-DOT employees______