

DOT TESTING COLLECTION REFERRAL FORM

Employer Name: _____ Client/Donor Name: _____

Social Security #/ID: _____ - _____ - _____

DOB: ____/____/____ Identification (DL#, Emp-ID#: _____

Type of testing requested:

Urine Lab Test

DOT 5 Panel (COC, OPI, AMP, THC, PCP)

Alcohol Test

DOT EBT Breath Test

Other Services

Background Check

Reason for test: Pre-Employment Random Post-Incident Suspicion Other

Special Instructions: _____

Test Must Be Taken By: _____
(Date or Dates)

AUTHORIZED BY: _____ DATE: _____
(Signature of DER)

(Print name of DER)

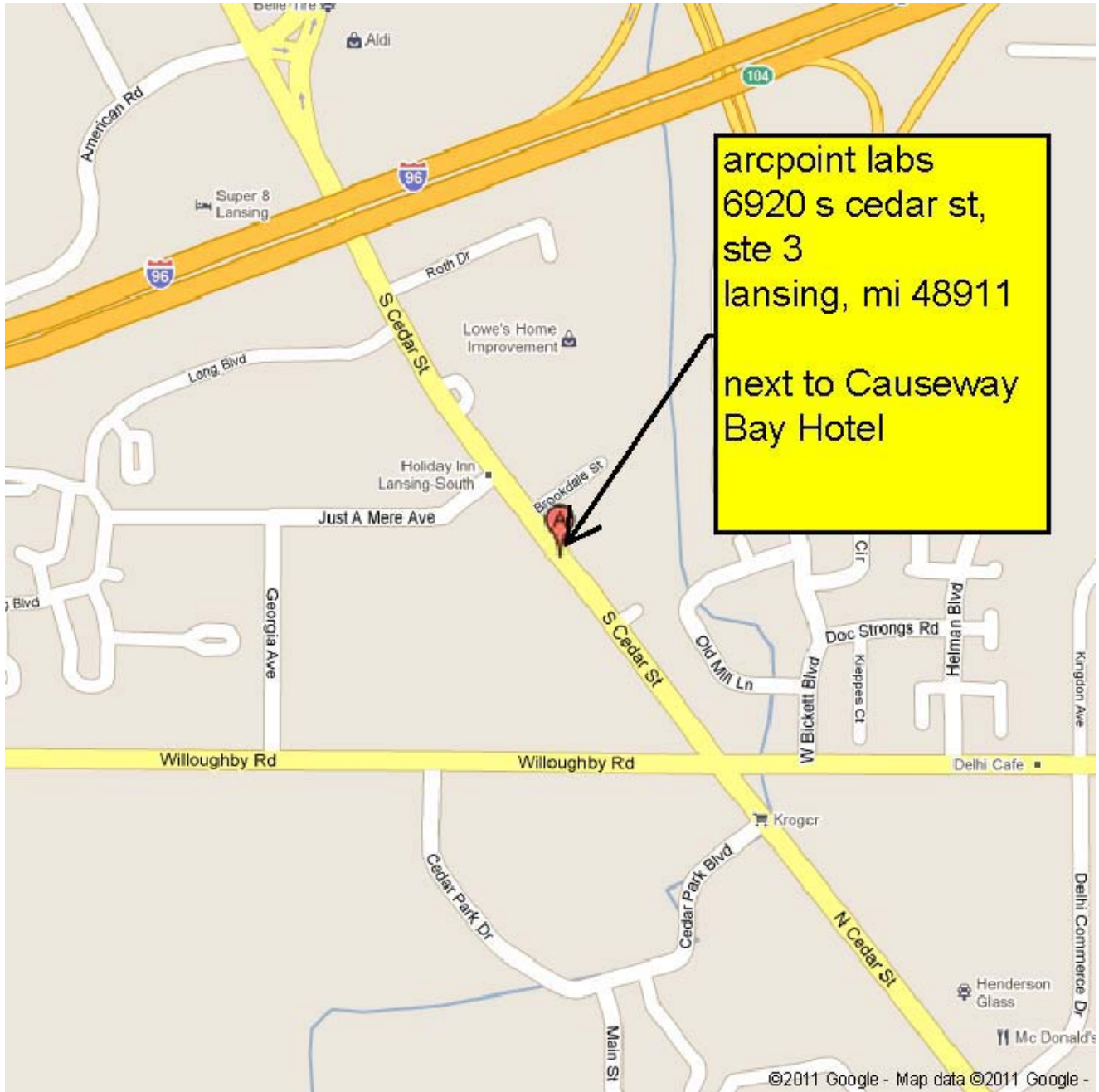
Designated Employer Representative (DER) contact Info:

Employer/DER Address: _____

Phone: _____ FAX: _____ E-mail: _____

Office Hours: Monday-Friday 8:30am-5:00pm with other times by appointment or service agreement

CLIENT INSTRUCTIONS: You **must** bring this form with you on the date scheduled above and present it to *ARCpoint Labs*' personnel in order to be tested. You **MUST** also have a **picture ID** with you for identification purposes. Failure to have these items will prevent the collection and screen. If you have questions, please call 517-215-7209.



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