NEW DOT POOL MEMBER REGISTRATION FORM

Print and complete all sections-return via email or fax and we will email you back an appointment time

Company/Carrier Name: _____

Has your company ever been a member of this program before? ____Yes ____No

If yes, under what company name: _____

Company owner's name: _____

Primary Contact /DER: _____

Phone: _____ Cell Phone: _____ E-mail: _____

Mailing/Billing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Business phone: _____ Fax: _____

Alternate Contact: _____

Phone: _____ Cell Phone: _____ E-mail: _____

Results will be sent via (**circle only one**): Secure Fax Confidential E-mail Client Web Portal

Secure reporting Password: _____ must be 8 to 20 characters and must contain 3 of 4:

Uppercase, Lowercase, Number, Special Character

US DOT # _____ MC# _____ Avg. # of drivers' _____

If you will be the only driver operating your truck (under your own authority), you are considered a single "owner/operator". If you have more than one driver, you are considered a "company". **Are you a:** ____ Company or ____ Single owner/operator Would you like to designate us to act on your behalf through the FMCSA Clearinghouse to report violations, return to duty test results and successful completion of follow-up testing and to conduct queries: Yes or No Would you like us to provide the required DOT drug and alcohol policy: Yes or No choose one below:

Policy 1 Terminate employee Policy 2 Employee pays for SAP Policy 3 Company pays for SAP

Would you like to register for the DOT required on-line supervisor training? Yes or No

RETURN THE COMPLETED FORM: FAX 530 751-4914 ore EMAIL ahrodrugtesting@ah.org

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Clinic use only:

Application date: _____ Medtox #: _____ Family #: _____ Billing #: _____