

American Drug Testing Consortium – Enrollment Application / Agreement

Print this page and fill out the information

(print name) I, _____ hereby apply for membership in **American Drug Testing Consortium - for random selection drug & alcohol testing.**

Enclosed is \$45/person for the annual membership fee. I am also including one of the following:

- (A) I have not had a drug test within the past six months. I need you to send me for one so I am including an additional \$80 for my pre-employment test (\$100 in Alaska) for a total of \$125 (\$145).
- (B) I have taken a drug test within the past six months so a pre-employment test is not needed.
I am including a copy of the test results signed by a Medical Review Officer (MRO).
- (C) I was a member of another random drug testing program during the previous twelve months, but have not been selected for testing. A pre-employment test is not needed. I am **including proof of my membership in the former group with this application.**

I understand that by joining this consortium and not refusing to be tested when selected, I meet the necessary requirements as listed in 46 CFR Parts 4, 5, and 16, 49 CFR Part 40, & 14 CFR Part 120 for drug & alcohol testing for DHS, DOT, FMCSA & FAA. I further understand that my continuous membership will require payment of an annual fee in addition to the charge for testing and processing the sample whenever I am randomly selected.

If I change my mind about joining this consortium, I will receive my \$45 membership fee back if I request it within 30 days of the date of this application. I also understand that I may request removal of my name from membership for any reason, at any time, by notifying American Drug Testing Consortium, or by not renewing my membership on any January 1st.

Signature _____ Date _____

Address _____ City, State, Zip _____

Social Security # _____ Day Phone _____ Eve / Cell Phone _____

CDL Driver USCG Captain's License Holder Crew Member Aviation Service Non-DOT Other _____

All correspondence is to be sent to _____ Above individual _____ Company
For companies with more than one person enrolling, please use copies of this form or add a list with the information.

Company _____ Address _____

City, State, Zip _____ Company Phone # _____

Drug Testing Administrator _____ Company Email _____
(Yourself, if you have a one person company)

How did you hear about us? Google Yahoo Print Ad Other _____ Existing Member's Name _____

Send, fax or scan & email this application and (A), (B) or (C) above, along with your check, or credit card information to:
"American Drug Testing Consortium" 6279 Main Street, Trumbull, CT 06611 Phone & Fax 1-800-528-9075

For Credit Card payment, # _____ Expires _____ Visa or MasterCard only

Billing Name and Address on CC _____
If different from above applicant.