

**American Drug Testing Consortium – Enrollment Application / Agreement**

**Print this page and fill out the information**

Company Name \_\_\_\_\_ hereby applies for membership in **American Drug Testing Consortium - for random selection drug & alcohol testing.**

Address \_\_\_\_\_ Email \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_

Drug Testing Administrator \_\_\_\_\_ (Person to receive all correspondence)

Name of Applicant \_\_\_\_\_ Social Security # \_\_\_\_\_

**Companies with more than one person enrolling, include a list of names and Social Security numbers.**

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

**Enclosed is \$60/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 \$60 for my pre-employment test for a total of \$120.
- (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/we understand that by joining this consortium and not refusing to be tested when selected, we 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. We further understand that continuous membership in the consortium will require an annual payment of the membership fee in addition to the charge for testing and processing the sample whenever randomly selected.

If we change our mind about joining this consortium, we will receive back any membership fees paid if it is requested within 30 days of the date of this application. We further understand that we may request removal of our name from membership for any reason, at any time, by notifying American Drug Testing Consortium, or by not renewing our membership by the next January 1<sup>st</sup>.

How did you hear about us?  Google  Yahoo  Print Ad Other \_\_\_\_\_

**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** \_\_\_\_\_  
(Please print clearly)

Email: [drugtestingconsortium@gmail.com](mailto:drugtestingconsortium@gmail.com)

[www.AmericanDrugTestingConsortium.com](http://www.AmericanDrugTestingConsortium.com)