

**EMPLOYER NEW ACCOUNT INFORMATION**

Name of Employer \_\_\_\_\_ Date \_\_\_\_\_

Type of service requested:  Workers Comp  Drug/Alcohol Testing  Pre-Employment Exam

**Billing Address for Services**

Name \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

\_\_\_\_\_  
Contact Person Phone Fax Number

**Workers Comp Carrier Information**

Name \_\_\_\_\_ Policy No. \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

\_\_\_\_\_  
Contact Person Phone Fax Number

Would you like for us to be your medical review officer (MRO) for drug testing?  Yes  No

If you already have an MRO and checked no, please provide the following information:

Name \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

\_\_\_\_\_  
Contact Person Phone Fax Number