SonicTest LABS
RESULTS YOU CAN RELY ON

Drug Testing Consortium in Phoenix, Mesa, Tempe - SonicTest Labs

Date:

Company Name:

☐ New ☐ Reinstatement

Main Contact Name:

Billing Contact: ☐ Same

Mailing Address:

Physical Address: ☐ Same

Billing Address: ☐ Same

City, State, Zip

City, State, Zip

City, State, Zip

Email:

Who Referred You To Our Consortium?

Of Employees:

Authorized to receive drug screen results and preferred method: (Please list below or attach in a separate pdf).

Choose File No file chosen

1.	phone/fax/email:	
2.	phone/fax/email:	
3.	phone/fax/email:	

Type Of Business: (i.e. trucking, construction, etc.)

Employee Name	Social Security Or Employer ID #
1.	#
2.	#
3.	#
4.	#
5.	#
6.	#

Are you currently enrolled in a Random Drug Testing Program? ☐ Yes ☐ No

If Yes, Consortium Name:

Type of testing your company requires: ☐ DOT ☐ Non-Dot

Please Note: All DOT Employees Must Provide Proof Of a Negative Drug Test, or Previous Consortium Enrollment, Before They Will Be Enrolled In The Consortium Program.

To Use A Previous Drug Test, It Must Have Been Taken Within 30 Days Prior To Joining The Consortium

With my signature, I hereby agree to participate in SonicTest Labs consortium and further agree to abide by its rules, policies and procedures. Upon receipt of my signed application and payment, SonicTest Labs will forward me a complete membership package, which will include proof of membership and rules and regulations.

Authorization Signature:

Date:

Submit Your Request