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CLIENT DATA SHEET

LOCAL COMPANY INFORMATION

*PLEASE PROVIDE THE FOLLOWING INFORMATION AS IT RELATES TO THE **LOCAL COMPANY** THAT THE TESTING IS BEING ORDERED FOR.*

Local Company Name:		
Local Company Mailing Address:		
Local Company Physical Address: *(if different from above)*		
Local Company Phone:	Type of Business:	Number of Local Employees:

Company Contact Information: *These individuals should be IRFDO contacts that can be reached by our staff in the event that an appointment is broken RU unacceptable specimens are presented*

Local Primary Contact Name:		Primary Contact Title:
Primary Phone:	Primary Fax:	Primary Email:
Local Secondary Contact Name:		Secondary Contact Title:
Secondary Phone:	Secondary Fax:	Secondary Email:

COMPANY SPECIFIC SERVICES

Toxicology Testing *Please check all that apply*

☐ *Urine Drug Screening* ☐ **DOT** ☐ **Non-DOT**

Chain of Custody Forms:

☐ Donor will bring in company specific chain of custody form each testing event

☐ Company specific chain of custody form will be provided to Marvel Laboratories to retain on file for donors

☐ ***Use Marvel Laboratories generic chain of custody form, if yes, select testing type below:***

☐ DOT Drug Screen	☐ DOT agency your company is regulated by: ☐ FMCSA ☐ PHMSA ☐ FTA ☐ FRA ☐)$ ☐ USCG		
☐ Non-DOT 5 Panel	☐ Non-DOT 7 Panel	☐ Non-DOT 9 Panel	☐ Non-DOT 10 Panel
☐ Non-DOT 11 Panel	☐ Non-DOT 12 Panel	☐ Confirmation of non-negative rapid test	

Specific Instructions/Comments:

BILLING FOR SERVICES

☐ /RFDOFRPSDQ\'DGGUHVVLVELOOLQJDGGUHVV		
☐ /RFDOFRPSDQ\,6127ELOOLQJDGGUHVV ELOOLQJVKRXOGEHGLUHFWHGWR	&RPSDQ\1DPH	
	&RPSDQ\0DLOLQJ$GGUHVV	
	$FFRXQW&RQWDFW 1DPH	
	$FFRXQW &RQWDFW3KRQH	)D[
	Account Contact Email	

3OHDVHOLVWDQ\VSHFLILFELOOLQJLQVWUXFWLRQVVXFKDVLQIRUPDWLRQUHTXLUHGRQWKHLQYRLFHPXOWLSOHELOOLQJDGGUHVVHVHWF

Account Contact Email	

Please list any specific billing instructions such as information required on the invoice, multiple billing addresses, etc.

I am an approved representative of the company listed above. I hereby agree to pay for services as outlined in the Husker Health fee schedule that I have been provided a copy of. I understand that Husker Health reserves the right to change the fee schedule at any time with 30 days written notice. I have been provided with a copy of the Notice of Privacy Practices for Husker Health and agree to abide by this practice.

Signature: Date: