Client Discovery Form for New Account

Questions and form submission: Accounts@applya.com

DER Contact

Name	Email
Phone	Fax
Company Name	Co. Address

Billing

Name	Email
Phone	Fax
Billing Address	

Are you participating under the MMCAP Infuse contract? ☐ Yes ☐ No **If Yes, please provide Infuse Member#**

Client Screening Requests

1. What type of drug testing do you currently perform?

☐ DOT Only - **Please Select Agency:** ☐ FMCSA ☐ FTA ☐ FAA ☐ USCG ☐ PHMSA ☐ FRA

☐ Non-DOT Only - If conducting Non-Regulated (Non-DOT) testing please indicate panel'(s):_____

☐ Both DOT & Non-DOT MRO Review* ☐ Yes ☐ No *DOT is required to have an MRO review.

2. What type of testing would you like performed?

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-Accident ☐ Return to Duty ☐ Follow-Up

☐ Other

3. Do you have a specific panel or substance(s) you need tested? ☐ Yes ☐ No **custom panel please specify**

If yes please specify: Multiple please write in What Testing Methods do you require? (Urine,Hair,Nail, Saliva ect..) Urine and Hair

4. How many employees are you looking to test? _____

5. Do you currently have or plan to have a random program? ☐ Yes ☐ No

☐ DOT Only ☐ Non-DOT Only ☐ Both DOT and Non-DOT

What are your Random **Testing Rates?** **For DOT** Drug % Alcohol % **For Non-DOT** Drug % Alcohol %

Number of random pools? DOT Non-DOT

6. Do you need random program management? ☐ Yes ☐ No

7. How frequently will you random pool test if implemented? ☐ Monthly ☐ Quarterly

8. Do you have a need for post-accident or after-hours testing? ☐ Yes ☐ No

9. Do you currently have a drug and alcohol testing policy? ☐ Yes ☐ No

10. Do you use a current collection site(s)? **(if yes, please send a copy)** ☐ Yes ☐ No

11. Do you currently do background screenings? ☐ Yes ☐ No

12. Do you have more than one department? **(if yes, please send list)** ☐ Yes ☐ No

13. What is the maximum mileage from the office to collection site? **(please provide a list of office addresses with zip codes to all locations collection sites are to be matched to)** **Miles** ☐

Occupational Health

1. Do you need physicals ? ☐ Yes ☐ No If Yes, what kind?

2. Do you need vaccines? ☐ Yes ☐ No If Yes, please list

3. Other Occupational Health Service Needs? ☐ Yes ☐ No If Yes, please list

Additional DER's

(Who will need access to the platform to order and or view results)

DER Contact	Permission Level :	☐ Order Test & View Results	☐ Order Test Only	☐ View Results Only
Name		Email		
Phone		Fax		
Company Address		Dept/Program		

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Name		Email		
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Name		Email		
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DER Contact	Permission Level	☐ Order Test & View Results	☐ Order Test Only	☐ View Results Only
Name		Email		
Phone		Fax		
Company Address		Dept/Program		

CLIENT ACCOUNT SET UP-LOCATIONS

IF Additional Locations

(parent-child account/sub account dynamic)

Client Name (parent account)		Location Name	Location Address 1	Location Address 2	City	State	Zip code	Phone	Fax
Main Account	1								
		Location Name (child account)	Location Address 1	Location Address 2	City	State	Zip code	Phone	Fax
	2								
	3								
	4								
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