Company Information Form

DOT EXPRESS
Medical Clinic

Date_____

Company Name: _____No. of Employees: _____

Company Address: _____FTIN:_____

Company Phone: _____Fax: _____

Company Contact:_____Email:_____

Accounts Payable Contact

Contact Name:

_____

Phone:

_____

Email:

_____

Fax:

_____

Services for Visit

[ ] Pre-employment Physical

[ ] DOT Physical

Drug Screens

[ ] DOT Drug Screen

[ ] Instant 10-Panel Drug

[ ] Non- DOT Standard 5-panel

[ ] Oral Saliva Testing

Urine Collection Only

Lab Name: _____

(Make sure Employee brings CCF form, if collection only)

Results Reporting Preference

Name : _____

[ ] Email: _____

[ ] Fax: _____

Other Services

[ ] BAT Breath Alcohol Test

[ ] Lift Test

[ ] Rapid COVID-19 Antigen Test

[ ] TB PPD Skin Test

[ ] Other

Thank you for choosing DOT Express for your occupational needs
Please fax completed form to: 702-476-9951 or scan and email to: Info@dotexpress.us