

DRUG FREE TRANSPORTATION ALLIANCE

CLIENT REGISTRATION FORM – DOT

Today's Date: _____ Please circle one: CORPORATION / PROPRIETOR

Company: _____ No. of Drivers: _____

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Secured voice mail? Yes ___ No ___

FAX: _____ Secured fax? Yes ___ No ___

E-mail: _____ Secured e-mail? Yes ___ No ___

Persons authorized to receive drug screen and breath alcohol test results:

_____ Day phone: _____ Evening phone: _____

_____ Day phone: _____ Evening phone: _____

Driver Enrollment

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Date of Birth: _____

DOT Medical Exam Certificate Expiration Date: ____/____/____

Date of pre-employment drug test: _____ **Location:** _____

Hire date: _____ **OR** Termination Date _____



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