



ONSITE REQUEST

Employer/ Company: _____

Billing Address: _____

DER: _____

DER Contact #: _____

ONSITE LOCATION

Address: _____

City/State: _____

Zip Code: _____

Date Requested: _____

Time Requested: _____

Number of Employees to be Tested: _____

DOT

NON -DOT

Services Requested:

10 Panel Urine Drug

12 Panel Urine Drug

10 Panel Rapid

Breath Alcohol

5 Panel Hair Drug Test

10 Panel Oral Drug Test

OTHER: _____