

**MMTA CONTROLLED SUBSTANCES
TESTING PROGRAM APPLICATION
(FILL OUT AND RETURN WITH PAYMENT)**



APPLICATION DATE: _____

Are you a member Maine Motor Transport Association?

YES NO

BASIC CUSTOMER DATA

Company Name _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone Number (____) _____ Extension _____

Fax Number (____) _____ E-mail: _____

Contact Person (Designated Employer Representative):

Print _____ Title _____

Please list your Preferred Collection Site(s): _____

- For multiple locations, please list them on the back of this application

My signature below represents our company's acceptance of the following terms:

1. To pay C/TPA, MMTA, or any service provider for services rendered as part of the program;
2. To update company information with MMTA and C/TPA if changes are made to address, contact, or other company information;
3. To add or delete drivers with C/TPA as employees are hired or terminate employment; and
4. To test as selected, prior to the end of each selection period and to release C/TPA and MMTA from any liability due to company's failure to complete required testing.

Signature _____

Preferred Method of Receiving Test results: (Circle One)

E-Mail Web Site Fax Mail

Method of Payment: check invoice (established accounts only) credit card (must call to process)

Make Check Payable to: MAINE MOTOR TRANSPORT ASSOCIATION
P.O. Box 857
Augusta, ME 04332-0857



MMTA DRUG TESTING PROGRAM RANDOM ADDITION/ DELETION FORM



COMPANY NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (____) _____ FAX: (____) _____

CONTACT: _____ TITLE: _____

EMPLOYEE LIST

(PLEASE TYPE OR FINE PRINT NAMES AND *LAST FOUR NUMBERS* OF SOCIAL)

ADDITIONS

DELETIONS

*IF MORE SPACE IS NEEDED, PLEASE COMPLETE ON THE BACK OF THIS FORM.

