

NORTH AMERICAN TRANSPORTATION SAFETY ALLIANCE

CONTROLLED SUBSTANCES TESTING PROGRAM

APPLICATION DATE: _____

ASSOCIATION DATA:

Are you a member of a State Trucking Association?

YES

NO

If yes, which State: _____

BASIC CUSTOMER DATA

Company Name _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone Number (____) _____ Extension _____

Toll-Free Telephone Number 1-800 _____

Fax Number (____) _____ E-Mail Address _____

Contact Person (Designated Employer Representative) (Print) _____

Title _____ Signature _____

Number of Drivers _____ Number of Terminals _____

Preferred Method of Receiving Test results: (Circle One)

___E-Mail ___Web Site ___Fax ___Mail ___Phone

Name of Doctor/Clinic doing DOT physicals (Optional) _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number (____) _____ Extension _____

Fax Number (____) _____ Toll-Free Telephone Number 1-800 _____

Make Check Payable to: MMTA
10 Liberty Square, 5th Floor
Boston, MA 02109
888-401-MMTA