

CENTRAL MEDICAL REVIEW

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(209)-333-1751
FAX 333-2868
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RANDOM DRUG TESTING PROGRAM ROSTER

1: Please list all persons who will be authorized to receive results of drug tests, and their titles:

2: Please indicate who should receive notifications of testing to be performed (Company Contact). Notification to test should be in keeping with the CMR contractual agreement and DOT regulations.

3: Please provide the following information for all employees holding a commercial driver license who will be involved with driving, maintaining, or loading vehicles which meet the requirements for this program. Contact us at CMR if you do not know whether your vehicles fall under these guidelines. Please save a master copy of this form for changes that may be made in future. CMR will not add/delete any driver without this form.

COMPANY: _____ **DOT number:** _____

| NAME <small>First, Middle Initial, Last</small> | SOCIAL SECURITY SECURITY (optional) | DRIVERS LICENSE | State for Drivers License | EMPLOYEE NUMBER | DATE OF BIRTH | A= Add D= Delete |
|--|---|--------------------|---------------------------------|--------------------|------------------|---------------------|
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| | XXX-XX-____ | | | | | |

SIGNATURE: _____ DATE: _____

Printed name: _____

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| <u>NO ROSTER CHANGES CAN BE MADE WITHOUT SIGNATURE</u> |
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Ben G. Watson, M.D., A.A.M.R.O.