

**MIDWEST SERVICE CORPORATION**  
**EMPLOYEE ACTION FORM**

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Company Name: \_\_\_\_\_ Member No.: \_\_\_\_\_

Contact Person 1: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Contact Person 2: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Collection Site Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please **ADD** the following to our Drug-Free Workplace Program effective: \_\_\_\_\_  
(Date)

Signature of contact person: \_\_\_\_\_

**Note:** A pre-employment drug test will be scheduled for the applicant(s) if you have chosen to conduct pre-employment testing. The contact named above will be contacted by a collector, and the test will be conducted at the site requested by you, or it will be sent to the clinic you chose (for clinic-based testing).

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DL#/ID#: \_\_\_\_\_ State Issued: \_\_\_\_\_ Class: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DL#/ID#: \_\_\_\_\_ State Issued: \_\_\_\_\_ Class: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DL#/ID#: \_\_\_\_\_ State Issued: \_\_\_\_\_ Class: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DL#/ID#: \_\_\_\_\_ State Issued: \_\_\_\_\_ Class: \_\_\_\_\_

Please **REMOVE** the following to our Drug & Alcohol Testing Program effective: \_\_\_\_\_  
(Date)

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Signature of contact person: \_\_\_\_\_

**PLEASE PRINT OR TYPE ALL NAMES & INFORMATION REQUESTED**

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