RANDOM TESTING DRIVER CHANGE LIST FORM
IOWA DRUG AND ALCOHOL TESTING PROGRAM **NO. 405.8**
Exhibit H

Date: _____

School District Contact Person: _____

School District: _____

Phone: _____

Address: _____

_____
Social Security Number and Name (first and last).

_____ _____
Additions Deletions

SSN Name SSN Name

Please list all qualified drivers who must be tested under the federal regulations. Make copies of this form if you need additional space. Changes must be made in writing. Telephone changes cannot be accepted.

Changes for a month must be received the last business day of the prior month to be effective for the month. Random list updates cannot be data entered for a new month if this form is received on or after the first of the new month.
Please fax or mail to:

Medical Enterprises, Inc.
200 Essex Court
Omaha, Nebraska 68111
402-393-8946

Approved: 07/28/03 Reviewed: ~~04/25/16~~ ~~11/12/18~~ 08/07/23 Revised: _____