

RANDOM TESTING DRIVER CHANGE LIST FORM  
IOWA DRUG AND ALCOHOL TESTING PROGRAM

School District  
Contact Person: \_\_\_\_\_ Date: \_\_\_\_\_

School District: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number and Name (first and last). Example 111-22-3333, John Doe.

<u>SSN</u>	<u>Additions</u> <u>Name</u>	<u>SSN</u>	<u>Deletions</u> <u>Name</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

IDAPT participants please fax or mail to:

Medical Enterprises  
200 Essex Ct.  
Omaha, NE 68114  
FAX: (402) 393-8946