



Construction Data Services

AN INTERNATIONAL ON-SITE DRUG TESTING, SAFETY & MEDICAL MANAGEMENT COMPANY

**The CIB OF AGC
&
GREAT PLAINS LABORERS' DISTRICT COUNCIL
SUBSTANCE ABUSE TESTING
PROGRAM POLICY**

EXHIBITS

Office: 314-645-5577
800-439-1454

2348 Hampton Ave., St. Louis, MO 63139

Fax: 314-645-6767
866-645-6767

www.cdsonsite.com



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THE CIB OF AGC & GREAT PLAINS LABORERS' DISTRICT COUNCIL SUBSTANCE ABUSE TESTING PROGRAM CONTRACTOR REGISTRATION

Company Legal Name _____

Street Address _____

NO PO BOX

City _____ State _____ Zip _____

Phone Number () _____ Fax () _____

E-mail Address: _____

COMMUNICATORS

Please designate one (1) Primary and one (1) Alternate Communicator. Your Communicators will be the only persons from within your organization that will be able to request, receive and/or discuss testing result information.

The following person is designated as our **PRIMARY** Communicator:

The following person is designated as our **ALTERNATE** Communicator:

This agreement by and between CONSTRUCTION DATA SERVICES (CDS) and the above listed COMPANY consists of the following understandings and conditions: COMPANY designates CDS to act in the capacity of their agent as it applies to the services provided by CDS. COMPANY understands that information is to be requested only by its designated personnel (COMMUNICATORS) for the sole business purposes falling within the scope of their official duties.

Signature of Company Official _____ Title _____ Date _____

.....
For CDS use only

Received _____

Client # _____

PLEASE FAX TO: 314-645-6767 or 866-645-6767



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COMMUNICATOR AUTHORIZATION AND SETUP

A COMPANY OFFICIAL MUST DESIGNATE THE PRIMARY AND ALTERNATE COMMUNICATORS FOR YOUR COMPANY. YOUR COMMUNICATORS WILL ACT AS THE SOLE CONTACT PERSONS FROM WITHIN YOUR COMPANY AND WILL BE RESPONSIBLE FOR THE ADMINISTRATION OF THE PROGRAM AND THE RECEIVING OF NON-NEGATIVE TEST RESULTS

COMPANY OFFICIAL:

I authorize the below listed employees to act as our Communicators:

Signature of Company Official _____ Title _____

Company Name _____

INSTRUCTION FOR THE COMPLETION OF THIS FORM:

Each Communicator must submit a separate copy of this form signed by a Company Official indicating their individual password in the appropriate space. Your password can be up to ten (10) letters in length. Please select your password carefully, as it will be requested from you as a means of identification. CDS will assign your access number and notify you of such.

NO INFORMATION WILL BE RELEASED WITHOUT A VALID ACCESS NUMBER AND PASSWORD

The following person is to be our **PRIMARY** Communicator:

Name _____ Title _____

Cell Phone Number _____ Beeper # _____

E-mail Address _____

Password _____

The following person is to be our **ALTERNATE** Communicator:

Name _____ Title _____

Cell Phone Number _____ Beeper # _____

E-mail Address _____

Password _____

Please Fax To: 314-645-6767 or 866-645-6767



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REASONABLE SUSPICION DOCUMENTATION

Prepare this form every time an Employee is suspected of alcohol and / or drug use by actions, appearance or conduct which constitutes a major change in the person's appearance and / or behavior.

Employee Name: _____

Date of Observation: _____

Time of Observation: From: _____ AM or PM To: _____ AM or PM

Location _____

Observed behavior - circle all appropriate items:

SPEECH
 thick incoherent
 rapid excessive
 slurred

BALANCE
 unsteady
 swaying
 falling

WALKING
 stumbling
 staggering
 grasping for support

EMOTIONAL INDICATORS
 depression withdrawal
 anxiety moodiness
 alienation irritability

PHYSICAL INDICATORS
 pupils dilated cold sweats
 redness of eyes rapid breathing
 weight loss neglect of personal hygiene
 loss of appetite odor of marijuana
 tremors odor of an alcoholic beverage

Other abnormal behavior observed: _____

To the best of my knowledge and belief, this report represents the appearance, behavior and / or conduct of the above named employee, observed by me and upon which I base my decision to request said employee to submit to reasonable suspicion/cause drug and alcohol testing.

Above behavior witnessed by:

Signature of Company Official

Signature of witness

Date

Date

Please Fax To: 314-645-6767 or 866-645-6767



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THE CIB OF AGC & GREAT PLAINS LABORERS' DISTRICT COUNCIL SUBSTANCE ABUSE TESTING PROGRAM Approved Testing Locations

CLINICAL COLLECTION SITES

Contractors may send their employees to any of the approved clinical locations for testing. (See attached list). The majority of these locations are open from 8:00am - 5:00pm. Some are open on weekends. Contractors desiring to utilize a clinical location must contact CDS to obtain Chain of Custody Forms prior to sending a worker for a test. The clinic will not test your worker without a Chain of Custody Form.

SENDING AN EMPLOYEE TO A CLINICAL COLLECTION SITE FOR TESTING

If you are sending an employee to a clinical location for testing, you must follow these steps:

1. SUBSTANCE ABUSE TESTING NOTIFICATION FORM (See Exhibit D – Substance Abuse Testing Notification)

Contractors sending employees to any of the approved clinical locations for testing must complete the Substance Abuse Testing Notification Form and fax it to CDS before sending the employee for testing. Your completion of this form will expedite the receipt of your results. Without this form we have no way of knowing who the employee belongs to.

2. EMPLOYEE NOTICE OF POLICY & CONSENT (See Exhibit A)

Prior to sending an employee to a clinical collection, the employee needs to complete the Employee Notice of Policy, Consent and Release Form (EXHIBIT A). The contractor should fax the completed form with the Substance Abuse Notification Form (Exhibit D) to **866-645-6767**.

3. QUEST DIAGNOSTICS SUBSTANCE ABUSE TESTING REQUISITION FORM

This form is provided by CDS to contractors who request them. This is the actual chain of custody form that the laboratory utilizes to perform the test and will be required for testing at a clinical location.

These are the only testing forms allowed under this program.

Do not complete any portion of the form or separate it in any way. The collection site will complete the form at the time of the test. Send this form with the employee to be tested. The laboratory will not be able to conduct the test without this form.

4. PHOTO IDENTIFICATION

The employee must have some form of photo identification with him to take his test (i.e. Drivers License, State ID Card, School ID, etc.). **The clinic will not conduct the test unless the employee has a photo ID.**



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MEDICAL REVIEW OFFICER PROCEDURES

All samples confirmed as non-negative by the laboratory will be referred to the Medical Review Officer (MRO) for interpretation. The MRO is a licensed physician who has knowledge of substance abuse disorders and has received the appropriate medical training to interpret and evaluate an employee's positive test result as it relates to the employee's medical history and any other biomedical condition. Employees who receive a non-negative test result will be provided the opportunity to discuss the reason for the non-negative test result with the MRO.

Upon the MRO's receipt of a non-negative test result from the laboratory, CDS will contact the designated Communicator for the Local Union, who will contact the Employer for whom the employee is working. The Contractor Communicator will then notify the employee that he/she needs to contact the MRO as soon as possible. Employees who fail to contact the MRO within 2 days of their notification will be reported as a non-contact positive, and reclassified to the Inactive Suspended Pool.

During the conversation with the employee, the MRO will discuss any recent hospitalization, medical treatment and prescription medication the employee may be taking.

If the confirmed non-negative is due to a legitimate prescription, and the MRO is able to confirm such, the employee will be ruled as negative. If the confirmed positive is due to an illegal or unauthorized substance, the MRO will rule the employee as positive and advise him to contact the Health and Welfare Benefit Administrator. In addition to the referral, the MRO will explain the worker's right to have his original sample retested by another SAMHSA Laboratory of his choice.

Retest: Individuals testing positive shall have the right to request that their original sample be retested by a SAMHSA approved laboratory of their choice. The request must be made in writing to the MRO within twenty-four (24) hours of the notification of a Confirmed Positive Test. The Individual requesting the retest shall pay the initial cost for a retest in advance to the MRO. In the event that said retest should prove to be negative, the individual shall be reimbursed for the cost of the test and reinstated.

After the employee has concluded his conversation with the doctor, he should be instructed to wait for the MRO's decision. In most cases, CDS will be able to notify the Local Union Communicator of the MRO'S ruling within an hour. The Local Union Communicator will notify the Contractor Communicator of the MRO's ruling.

If the worker's test is confirmed and ruled as a positive test by the MRO, the designated Contractor Communicator will then provide the employee member with a copy of the reinstatement procedures (**See Exhibit G**). The employee member should acknowledge his understanding by completing the bottom portion of the form. The Contractor Communicator should then fax the completed form to CDS as soon as possible.

MRO PHONE #: 877-808-2929

