Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703 SUBSTANCE ABUSE TESTING POLICY

EXHIBITS

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EXHIBIT A

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS, LABORERS' LOCAL 159, 477 AND 703 SUBSTANCE ABUSE TESTING AND TREATMENT PROGRAM EMPLOYEE NOTICE OF POLICY, CONSENT AND RELEASE

Your Employer is a member of the Central Illinois Builders of AGC, the AGC of Illinois and Laborers' Local 159, 477 and 703 Substance Abuse Testing Program (Program), which prohibits the use, abuse, presence in the body, or reporting to work under the influence, bringing onto the worksite, the unlawful manufacture, distribution, possession, transfer, storage, concealment, transportation, promotion or sale of illegal and unauthorized drugs, controlled substances, alcoholic beverages or drug related paraphernalia by employees, and any of the foregoing is a violation of this Program and will subject the employee to disciplinary action, up to and including immediate termination.
.

The following types of testing will be conducted under the Program by use of urine, breath, saliva or blood:

Implementation Testing
Pre-Access Testing
Post-Accident/Incident Testing
Return-to-Work Testing
Pre-employment Testing
Random Testing
Reasonable Suspicion/Cause Testing
Follow-up/Probationary Status Testing

A copy of the Substance Abuse Testing Program's Policy has been provided to me. I understand that my refusal to submit to an alcohol or drug test, or my refusal to cooperate fully with the drug testing procedures, a positive test result, or any violation of the Program, will be sufficient cause for disciplinary action, up to and including immediate termination. Any and all discipline provided hereunder against union-represented bargaining unit employees shall be subject to the grievance/arbitration provision of the parties' applicable collective bargaining agreement.

This will acknowledge that I have read and understand the above and that I have been given a copy of the Program Policy and agree to comply with the Program. I consent to have trained personnel collect urine, breath, saliva or blood samples from me to determine the presence or use of illegal drugs or controlled substances and alcohol.

I authorize the release of my test results to my employer for employment purposes, my employer's Third-Party Administrator (TPA), the clinic, the laboratory, and the Medical Review Officer (MRO), as legally required and upon request to the parties of a grievance initiated by the employee or union. In addition, I authorize the TPA to add my name and related eligibility status to the Program database for other contractor companies that could be my future employers to view my eligibility status. In the event that my employer is subject to an owner-mandated substance abuse policy that the Board of Trustees determine satisfies the terms and conditions set forth in the Substance Abuse Testing Program's Procedures, then I consent and authorize my employer, my employer's Third Party Administrator (TPA), the clinic, the laboratory, and the Medical Review Officer (MRO) to share my test results with Construction Data Services (CDS) and hereby authorize CDS to add my name and eligibility status to the Program database. I understand that I have the option, by initialing here, [ ] to REVOKE my consent and authorization for my test results under an owner-mandated substance abuse policy to be shared with CDS, and <u>understand that by revoking my consent and authorization, I will not be removed from this Program's random pool</u>.

I authorize the MRO to verify my health information as it pertains to my drug test results with my prescribing physician and issuing pharmacist.

In the event the drug and/or alcohol test results are positive, I acknowledge that I have the right to request that the **<u>original sample</u>** be retested by a SAMHSA certified laboratory of my choice. The request must be made to the MRO within twenty-four (24) hours of when I am notified of a confirmed positive test. I shall pay the initial cost for a retest in advance to the MRO. In the event that said retest should prove to be negative, I will be reimbursed for the cost of the test, paid any back wages including benefits, and reinstated as an employee provided work is available.

Employee **SIGNATURE**	SSN / CIC ID Number	Craft/Trade

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

Employee **PRINTED** name Employer Date

Exhibit B

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703 SUBSTANCE ABUSE TESTING POLICY

EMPLOYER/UNION REGISTRATION

Employer/Union 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. I hereby authorize ☐ remove ☐ the following communicators:

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/UNION consists of the following understandings and conditions: COMPANY/UNION designates CDS to act in the capacity of their agent as it applies to the services provided by CDS. COMPANY/UNION 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. Communicators understand that all testing information is to be kept highly confidential.

Signature of Company Official **Title** **Date**

For CDS use only

Received _____ Client # _____

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

Exhibit C

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703 SUBSTANCE ABUSE TESTING POLICY

COMMUNICATOR AUTHORIZATION AND SETUP

EACH COMMUNICATOR MUST SUBMIT A SEPARATE COPY OF THIS FORM

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 AND POSITIVE TEST RESULTS. COMMUNICATORS DESIGNATED BY THE COMPANY OFFICIAL, UNDERSTAND THAT ALL TEST RESULTS MUST BE KEPT CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.

COMPANY/UNION OFFICIAL:

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

Signature of company official _____ Title _____

Company/Union Name _____

INSTRUCTIONS 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** ☐ **ALTERNATE** ☐ communicator:

Name _____ Title _____

Cell Phone Number _____ Beeper # _____

E-mail Address _____

Password _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

CDS will mail you a confirmation letter with you PASSWORD and an assigned ACCESS NUMBER. No information will be released to you by our office without furnishing us with this ACCESS NUMBER and PASSWORD.

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

Exhibit D

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703
SUBSTANCE ABUSE TESTING POLICY
SUBSTANCE ABUSE TESTING NOTIFICATION

Date _____ Employer _____ Submitted by: _____

Please complete and return by fax prior to sending a worker to a Clinical Location for testing.
This Notification Form allows us to contact the Clinic if there is an issue with the drug and/or alcohol collection.

PLEASE PRINT
Clinic Used

Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft

Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft
Last Name	First Name	SSN/Employee ID#	Craft

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

EXHIBIT E

CDS Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703
SUBSTANCE ABUSE TESTING POLICY
REASONABLE SUSPICION/CAUSE 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		**BALANCE**	**WALKING**
thick	incoherent	unsteady	stumbling

rapid	excessive	swaying	staggering
slurred		falling	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

EXHIBIT F

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703
SUBSTANCE ABUSE TESTING POLICY
REINSTATEMENT REQUIREMENTS

As a result of your confirmed positive drug or alcohol test, you have been placed in the Inactive Suspended Pool. While you are in this pool you are disqualified from employment with any signatory Company until the following conditions have been met:

A.Completion of a Substance Abuse Assessment, Rehabilitation and/or Treatment Program

1.You should contact your Medical Provider immediately to begin this process because:

a. Your failure to participate in an approved assistance program, or

b. Your abandonment of a treatment program prior to completion and/or being properly released will result in disciplinary action, up to and including immediate termination.

2. You must provide written proof to CDS of your completion, or release from an approved substance abuse counseling assessment, rehabilitation or treatment program prior to taking your return-to-work drug and alcohol test. This written proof needs to be faxed to CDS by the member or the treatment program at 866-645-6767.

3. The employee shall be responsible to pay $50.00 by money order only, made out to Construction Data Services, in advance to a designated collection facility, for the cost of the drug and alcohol tests.

advance to the designated collection facility.

B.A Negative Return to Work Drug and Alcohol Test

Upon the completion of your substance abuse assessment, rehabilitation or treatment program, you will be required to successfully pass a return-to-work drug and alcohol test. This test must be conducted at a designated collection facility approved by CDS. For further assistance, contact CDS at 1-800-439-1454.

C. Completion of Consequences for Violation of the Substance Abuse Testing Policy

Refer to the Substance Abuse Testing Policy for Consequences of Violation

D.Probationary Status

If you elected to participate in an Assessment, Rehabilitation and/or Treatment Program and have provided a negative return to work drug and alcohol test, you can be returned to the Active Pool and be eligible for employment with the Company under a probationary status. Employees being returned to the Active Pool will be subject to additional random testing at an annualized rate of fifty (50) percent for a period of up to twenty-four (24) months and up to six (6) of these additional random tests during the first year of your return to the Active Pool.

Employee signature _____ SSN / Union Card Number _____ Date

_____
Date

Employee PRINTED name _____ Employer

_____ _____
Witnessed by
Date

Date

Please fax completed form to: 314-645-6767 or 866-645-6767

EXHIBIT G

Construction Data Services

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

CIB-AGC, AGC-ILLINOIS AND LABORERS' LOCAL 159, 477 AND 703 SUBSTANCE ABUSE TESTING POLICY CHECK POOL STATUS

Employer: _____ By: _____ Date:_____

Access #: _____ Password:____

AC	INAC	RA	PEN	REINS

RETURN FAX # _____

PLEASE PRINT

Last Name	First Name	SSN/Employee ID#

Please fax completed form to: 314-645-6767 or 866-645-6767