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

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

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Form</th>
<th>Exhibit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Notice of Policy, Consent and Release</td>
<td>A</td>
</tr>
<tr>
<td>Employer / Union Registration Form</td>
<td>B</td>
</tr>
<tr>
<td>Communicator Authorization and Setup Form</td>
<td>C</td>
</tr>
<tr>
<td>Substance Abuse Testing Notification Form</td>
<td>D</td>
</tr>
<tr>
<td>Reasonable Suspicion Documentation Form</td>
<td>E</td>
</tr>
<tr>
<td>Reinstatement Requirements Form</td>
<td>F</td>
</tr>
<tr>
<td>Check Pool Status Form</td>
<td>G</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Implementation Testing</th>
<th>Pre-employment Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Access Testing</td>
<td>Random Testing</td>
</tr>
<tr>
<td>Post-Accident/Incident Testing</td>
<td>Reasonable Suspicion/Cause Testing</td>
</tr>
<tr>
<td>Return-to-Work Testing</td>
<td>Follow-up/Probationary Status Testing</td>
</tr>
</tbody>
</table>

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 understand that by revoking my consent and authorization, I will not be removed from this Program’s random pool.

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 original sample 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.

________________________________________  SSN / CIC ID Number  Craft/Trade

Employee SIGNATURE

09/10/2008

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

<table>
<thead>
<tr>
<th>Signature of company official</th>
<th>Title</th>
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**Company/Union Name**

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**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**

<table>
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<tr>
<th>The following person is to be our</th>
<th>primary ☐ alternate ☐</th>
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<tbody>
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<td>Name</td>
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<td>Password</td>
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CDS will mail you a confirmation letter with your 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.

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

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

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
- thick
- incoherent

BALANCE
- unsteady

WALKING
- stumbling
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
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 ___________

Employee PRINTED name ___________________________ Employer ___________________________

Witnessed by ___________________________ Date ___________

Date ___________________________

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

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