



Instructions

Fill out all the fields and sign both pages.

After completing all the information, email to:
med@safetypartners.org



Alcohol & Drug Testing Services Agreement

Master-Med LLC (*Consultant*) whose business is located at 1280 MARK ST, BENSENVILLE IL 60106 and

Company name (Client)	Address
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City, State, Zip	Phone Number	Fax
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E-mail	MC Number	DOT Number
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Hereby agree to the terms and conditions, on this date _____, set forth as follows:

- Consultant will be responsible for establishing that the Client is entirely compliant with every alcohol and/or drug testing requirement of the U.S Department of Transportation (DOT). This includes notifying the Client and its drivers which drivers are to be tested, when a test is required, and complying with all reporting requirements of DOT.
- The Agreement will be in effect from the date above to December 31st end of each year. The Agreement will automatically renew for another (1) year term unless terminated by Client, with at least 60 days written notice.
- To implement the duties under this Agreement, Client agrees to the following:
 - Client will maintain an updated drivers list at all times upon the obtainment of the quarterly eligibility list. Client will delete the names of any drivers who have been terminated or ineligible to be randomly selected for the upcoming quarter. Client will assure that the drivers list will include the current and new drivers name and social security number.
 - Client must date and sign the eligibility list and fax it back within 5 days.
 - Once the random selections are generated by Consultant, Consultant will fax or e-mail the Client its selections.
 - DOT requires Client to inform the selected employees.
 - If driver is unavailable for testing, the Client must document the reason, date and sign it, and fax it back to Consultant.
 - All random selections must be completed AS SOON AS POSSIBLE.
- I understand that only duly-authorized Consultant officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.
- I will hold harmless the Consultant, its company physician, and any testing laboratory the Consultant might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Consultant or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Consultant, its company physician, and any testing laboratory the Consultant might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above. Consultant will not be responsible for any damages, including attorney fees resulting from actions taken from Client's substance abuse policies. Client will not assert any claims against Consultant for damages claimed by a third party.
- This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

Company

Employer Representative (SIGNATURE)	Date
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Employer Representative (PRINT)	Date
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Consortium Coordinator

SIGNATURE

Appendix A – Information Access & Payment

Company (Client) hereby agrees to authorize a representative(s) to communicate with Master-Med LLC (Consultant) and represent Client. All representatives will be assigned a login ID and password for client information access on consultant's website. All personnel who have access to any information pertaining to the testing are listed below:

D.E.R: _____ EMAIL _____

D.E.R: _____ EMAIL _____

D.E.R: _____ EMAIL _____

D.E.R: _____ EMAIL _____

D.E.R: _____ EMAIL _____

Please check off each box to let us know who is responsible for paying the following tests:

<i>Type of Test</i>	<i>Driver</i>	<i>Company</i>
In office pre-employment		
Out of office pre-employment		
Random, post-accident, reasonable suspicion		

Company

Employer Representative (SIGNATURE) Date

Employer Representative (PRINT) Date