APPENDICES & FORMS

for

MECHANICAL SYSTEMS OF DAYTON, INC'S SUBSTANCE-FREE (DRUG-FREE) WORKPLACE PROGRAM

Specifications as of January 21, 2011

Program Implementation as of September 2004

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INTRODUCTION

Dee Mason and Working Partners Systems, Inc. have prepared these materials - including the sample policy and appendices - to assist businesses and public entities in their efforts to maintain a drug and alcohol-free workplace. We feel you will find these materials useful and state-of-the-art for addressing workplace substance abuse issues. Thank you for the opportunity to help your organization!

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Obtain Further Input

Dee Mason and Working Partners Systems, Inc. emphasize the importance of having your organization consult experienced and qualified attorneys, accountants, medical advisors, third-party consultants and other business professionals to assure the best results for organizing and building your business and for attempting to achieve a drug and alcohol free workplace, Dee Mason and Working Partners Systems, Inc. are not engaged in rendering any legal, accounting or medical advice or service upon which you can or should rely.

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APPENDICES & FORMS
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APPENDIX A

MSD'S
LIST OF SAFETY-SENSITIVE FUNCTIONS

Safety-Sensitive Functions - By their nature, it is deemed by the company that these work *activities* or "functions" carry higher risk to the employee, co-workers, customers or the general public. These functions meet the safety-sensitive criteria, "activities wherein a momentary lapse in attention could cause physical injury and/or death."

- While at or in a safety-sensitive environment
- While working with or handling potentially hazardous/combustible materials
- While driving a vehicle on behalf of the Company
- While operating motorized equipment
- While operating power tools
- While working with electrical wiring or current
- Other:

OHIO - SUBSTANCE TESTING INFORMATION

In our attempt to protect an applicant and employee's' privacy rights and to ensure that applicants/employees are treated fairly and with dignity when being tested for drugs and/or alcohol under the Company's Substance-Free (Drug-Free) Workplace Program, the following safeguards have been adopted.

1. Identification of the Drugs for Which the Company Will Test - Below is a list of the drug categories for which we are testing where the law permits along with some of the categorical brands and/or common names (not necessarily all inclusive). If needed, ask your Program Administrator for more information.

The drugs we will be testing for under this program are: Amphetamines (e.g. Ephedrine, Adderall, Dexedrine, Methamphetamine, "Speed," Crystal Meth, "Crank," "Uppers," "Whites Crosses," "Dexies," "Black Beauties"), Cannabinoids (THC, Marijuana, Hash), Cocaine (including Crack), Opiates (e.g. Heroin, Hydrocodone, Morphine, Codeine) and Phencyclidine (PCP). To create a selection of ten drugs, the Company can add: Barbiturates (e.g. Seconal, Phenobarbital), Methaqualone, Benzodiazepines (e.g. Valium, Librium), Methadone and Propoxyphene (e.g. Darvon, Darvocet).

MSD reserves the right to expand this list or adjust the cut-off levels stated here in order to mirror additional drug categories that are required at the federal level for mandated employees (e.g. MDMA, etc.). Furthermore, the Company reserves the right to require testing for another drug that is not on this list if there is documentable reason to believe that the employee may be under its influence and therefore safety and productivity may be compromised or if the Company needs to comply with a contract or regulatory authority.

2. Prior Use of Legal Drugs - Depending upon the law in the state of your worksite, you may be invited to list any drugs you have ingested in the previous 30 days *before* you take your test. In any case, should there be a positive drug test result; you will have an opportunity to discuss the results with the Company's Medical Review Officer (MRO). You will want to identify all prescription and non-prescription drugs you have used in the last thirty (30) days and to explain the circumstances surrounding their use.

3. Contacting the Lab for Technical Information – The Company will support and if necessary, assist in coordinating your direct interaction with the testing laboratory if you have any technical questions about the testing process.

4. Payment for Testing – MSD is responsible for the cost of testing required under this Program including time and reasonable transportation costs.

5. Providing the Specimen - There are a number of methods for conducting drug and alcohol tests. The individual may be directed to undergo one of the following specimen procedures:

a. Urine - For a drug test, the individual will be required to provide between thirty (30) and forty-five (45) milliliters of urine. If at first he/she is unable to do so, collection personnel will give him/her eight (8) ounces of liquid every thirty (30) minutes until he/she is able to do so. Unless there is documentable reasonable suspicion to think the employee has or will attempt to adulterate or manipulate the specimen collection process, generally, he/she will provide the urine specimen in private, without observation by collection site personnel.

b. Breath - For an alcohol test, the individual will be required to provide a breath sample measured in terms of grams of alcohol per 210 liters of breath. An Evidentiary Breath Testing (EBT) device will confirm the results of a preliminary test**.**

c. Saliva - For an alcohol test the individual will be required to have saliva collected by the use of a cotton swab and the level of alcohol in the saliva will be read by a saliva testing device. An Evidential Breath Testing (EBT) device will be used to confirm the results of the preliminary test.

d. Blood - For either an alcohol or drug test, the individual will be required to provide a blood specimen which is a minimum of one-half of one (1) 7 milliliter tube. Instead of an alcohol swab, a non-alcoholic prep is used prior to drawing the blood sample.

6. Accuracy of Test Results - The Company has taken precautions to assure the test results are accurate. Those persons administering the tests have been trained in their use. The Company has retained the services of a laboratory that uses state-of-the-art testing procedures. The legal, scientific and medical communities agree that this combination of tests used by the laboratory on urine and blood samples produces extremely accurate results.

a. Drug Test – Normally, urine will be used to test for drugs. The laboratory uses two (2) separate tests on urine. If the first test (e.g. EMIT) produces a positive result, the laboratory will administer a second, more sophisticated test (Gas Chromatography/Mass Spectrometry-GC/MS). This second test measures the exact "fingerprint" of each drug. Every drug has a different molecular structure, just as each person has a different fingerprint. Only if the second test is also positive does the laboratory report a positive test result.

b. Breath Alcohol Test – Normally a breath test will be used to confirm the level of alcohol present. The breath alcohol technician first tests the machine's accuracy by performing a reading of ambient air (containing no alcohol). Then the machine very accurately measures the alcohol level present in the individual's system at the time of the collection using gas chromatography technology.

c. Blood Alcohol Test - The laboratory uses the Gas Chromatography (GC) method. This test screens for the presence of ethyl alcohol and in turn measures the exact level of ethyl alcohol present in the individual's system at the time of the collection.

d. Split Specimen - This is a method for collecting and analyzing urine samples which is required as part of the compliance process for the federally-required testing. The total amount of urine normally collected is 45 ml. This specimen is divided into a primary specimen of 30 ml and a split specimen of 15 ml. In case of a re-test, the split specimen will be tested.

e. Chain of Custody - The laboratory has established specific methods to ensure the integrity of each bodily specimen that has been collected. As part of this process, collection personnel follow rigorous chain of custody procedures. Individuals providing urine and/or blood specimens also play a role in the chain of custody procedures by keeping their urine and/or blood specimen in view at all times until it is sealed, labeled and initialed.

7. Confidentiality - The test results and any information provided to the Medical Review Officer (MRO) are highly confidential. Only designated officials of the Company with a need to know will be informed of the results. (Refer to Attachment A *Explanation of Terms*, "Confidentiality.")

The Company will secure in a file other than a personnel file any drug and/or alcohol collection/laboratory testing paperwork; testing results; assessment/treatment referrals; and/or recommendations and results for an employee. You are entitled to inspect or copy information that is contained in that file. Such information may be automatically provided to you but at a minimum, it will also be provided upon submission of your written request.

8. Consequences of Refusal to be Tested - The Company will not offer employment to any person who refuses to be tested in accordance with the Company's Substance-Free Workplace Program. The Company may terminate, or otherwise discipline, any employee who refuses to be tested. "Refusal" includes (1) refusing to take a test when required by the Company, (2) not reporting an accident timely, (3) not reporting for a drug and/or

alcohol test in a timely manner as required by the Company, or (4) refusing to cooperate with the testing process.

9. Consequences of a Positive Test - A prospective employee's positive test result will be reported to the Company and the prospective employee will be denied employment. A positive test for an existing employee constitutes a violation which will result in "corrective action" ranging from relief of job duties to mandatory referral for substance abuse assessment to discipline, up to and including immediate termination (refer to Attachment A. *Explanation of Terms* "Corrective Action.")

10. Notification of Test Results – A prospective employee's positive test result will be reported to the Company and the prospective employee will be denied employment.

Before a positive test result of an existing employee is reported to MSD, the test will be reviewed by an outside medical review officer (MRO) who is a licensed physician. The MRO will attempt to contact the employee for further information. If an employee has a legitimate medical explanation for the positive test and the MRO has verified the explanation, the test will be reported as a negative to the Company.

If the test is ruled positive, the employee will receive a written notice within five (5) days.

11. Re-Test Process - An employee may challenge the results of the test by requesting a re-test of the original sample within 72 hours from the time he/she is notified by the Company of the positive test results. A re-test will be done on the original specimen by a SAMHSA-certified laboratory and, if found to be positive, the test will be at the expense of the employee.

12. Employment Benefits - If you are terminated as a result of the Company's Drug-Free Workplace Program, your termination notice will indicate "misconduct–rule violation" as the reason and may affect your ability to qualify for employment benefits including unemployment and/or workers' compensation.

GUIDELINES FOR EMPLOYEE REFERRAL TO DRUG/ALCOHOL TESTING BASED ON REASONABLE SUSPICION

The Company's supervisors and/or managers ("supervisors") must be alert to declining job performance, inappropriate behavior and other symptoms of possible substance abuse. Whenever a supervisor has reasonable suspicion to believe substance abuse may be causing an employee's performance or behavior problems, consider the following guidelines:

A) Document in writing all circumstances, information and facts leading to and supporting your suspicion. Include dates and times of unsatisfactory performance or questionable behavior, any reliable/credible sources of information and any objective evidence giving rise to the suspicion. Apply Form D-3, *Reasonable Suspicion Observation Checklist.*

B) In those cases where the supervisor and/or witness determines that the employee's performance and/or behavior raises a safety issue or a potential threat of harm to him/her or others, the employee should be immediately removed from the work area to secure safety.

C) Review the Company's Substance-Free (Drug-Free) Workplace Program to assess what type of Program violation has occurred.

D) 1) If the situation occurs during normal business hours, the supervisor should attempt to contact the Program Administrator (or her designee) to confer regarding what type of a violation of the Company's Drug-Free Workplace Program has occurred, what corrective action should be imposed and whether drug and/or alcohol testing is necessary and/or should be required.

2) If the situation occurs during an alternate shift, the supervisor, once having made the decision to proceed, should confer (if possible) with the Program Administrator or Designee (or another trained supervisor who has experience with such behavior/situations) to discuss/confirm the finding of reasonable suspicion and/or a decision to refer the employee to testing.

Attempt to obtain such input before referral of the employee for testing.

NOTE: The Company-authorized Assistance Services can provide general information on substance abuse, assistance in determining the extent to which an employee's performance and/or conduct problems are related to substance abuse, and background information on re-integrating non-terminated employees back into the work force.

E) If no referral to testing will occur, the supervisor and witness(es) (where feasible) should communicate to the employee what corrective action will be imposed. This communication should occur in a private, confidential setting. They should discuss with the employee items listed under (G) of this document.

F) Once a determination has been made to refer the employee for testing, the Program Administrator or Designee should:

1) notify the collection facility that an employee is being sent for testing and question whether a qualifying EBT is available. (The supervisor should confirm where qualifying EBT testing will occur or arrange for a blood-alcohol collection.) Further, the collection facility should be instructed to notify the supervisor and/or witness when collection procedures are completed; and

2) when appropriate, make arrangements to transport the employee to the collection site for the drug and/or alcohol test and to home or back to the Company following the collection process; and

3) ready a copy of the *Substance Abuse Testing Consent Form* (Form D-2*)* if the employee does not already have a signed copy in his/her personnel file; and

4) prepare any necessary paperwork: i.e. *Drug/Alcohol Testing Collection Site Instruction Form* (Form D-4) for the employee to take or to be faxed ahead to the collection site; and

5) within 24 hours, notify the Company President if otherwise not notified.

NOTE: For the safety of the employee, other employees, and the general public, steps should be taken to attempt to ensure that the employee in question does not drive a vehicle. If the employee refuses assistance with transportation, inform the employee that it will be considered a violation of this Program and he/she will be subject to corrective action, up to and including termination. Further, inform the employee that law enforcement officials will be called and notified of the employee's license plate if he/she drives. If the employee drives off the Company premises, the Program Administrator/ Designee will call local law enforcement explaining the situation and providing the employee's license plate number. Ultimately however, it is the employee's choice whether to accept Company-provided transportation.

G) In a confidential manner and in a private location, the supervisor and witness(es) (when available**)** should discuss with the employee:

- the facts and instances of questionable performance and/or behavior;
- whether the employee is required to go for a reasonable suspicion test; and
- what will be the employee's work status following specimen collection (on or off the job, with or without pay).

Either the individual who was contacted and conferred with above in (D) or another trained supervisor should serve as a witness to the discussion, (where feasible).

H) The supervisor should officially acknowledge the employee's time off-the-clock, escort the employee to the waiting transportation and receive notice from the collection site when the employee has completed the collection process.

I) In those cases where a supervisor discovers an employee possessing what appears to be an illegal drug or alcohol, he/she should:

1) ask to confiscate the substance and any related paraphernalia (handle as little as possible, if possible wear gloves). If the employee refuses to cooperate, local law enforcement officials can be called,

2) wrap any confiscated substance and related paraphernalia in any available clean material (e.g. paper towel, copier paper, handkerchief) and keep the package in a locked and secure place where it cannot be tampered with,

3) if not right away, as soon as possible, put the still-wrapped materials into a large envelope, seal the envelope completely, write his/her initials *over* the seal of the envelope in several places, write the employee's name on the envelope, and the date at the top of the envelope, and

4) turn over the envelope as soon as possible to the Program Administrator or his/her designee. That person will then become responsible for turning any illicit substances over

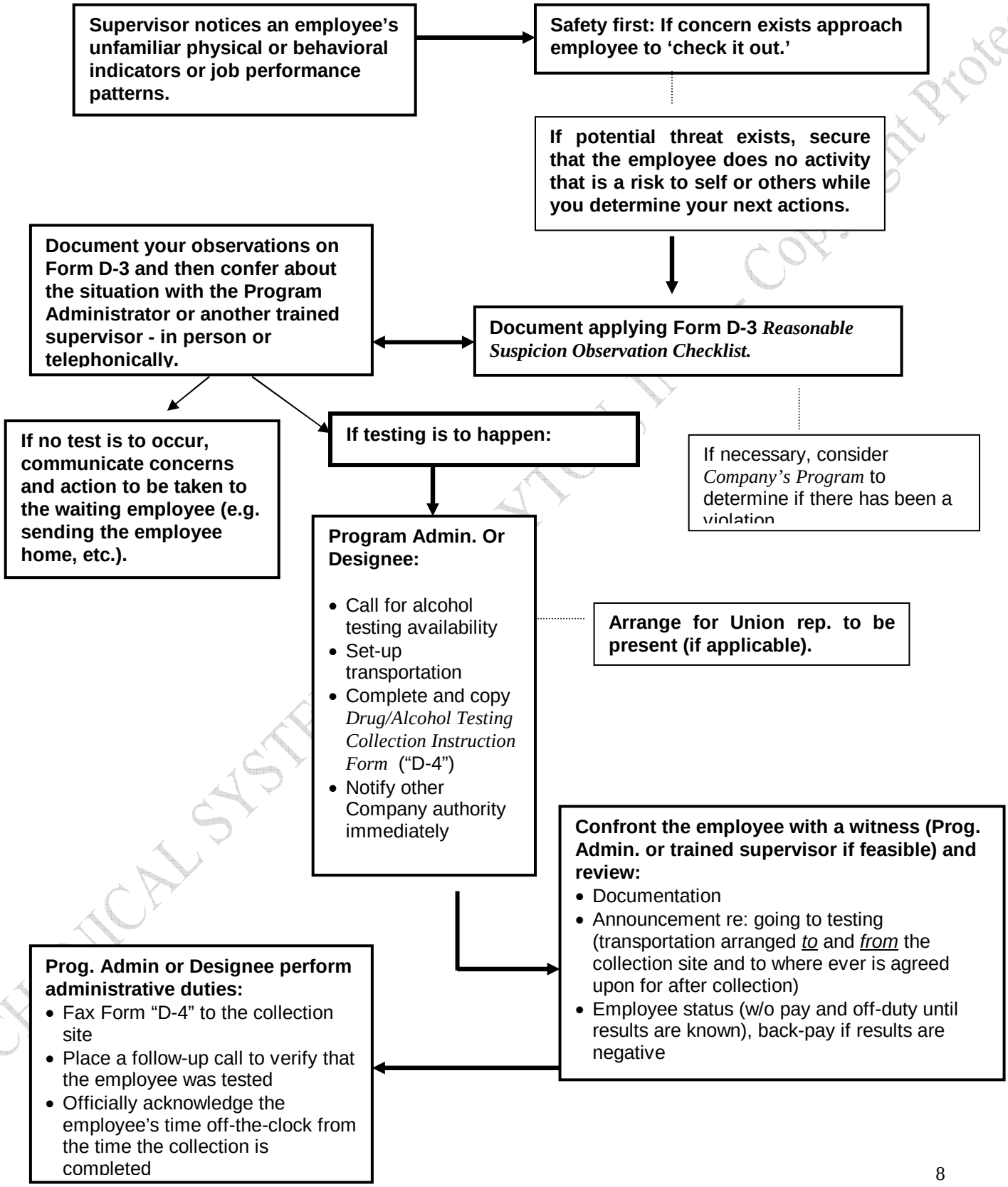
to local law enforcement officials. The supervisor and the Program Administrator should witness and document when and to whom from local law enforcement the envelope was turned over.

NOTE: The Program Administrator/Designee should be called immediately if any unattended substance that appears to be an illegal drug or paraphernalia is discovered. He/She in turn will call law enforcement authorities and assist in their confiscation of the substance(s).

REMEMBER TO DOCUMENT! DOCUMENT! DOCUMENT!

APPENDIX C-1

- REASONABLE SUSPICION TESTING–
STEPS FOR REFERRAL



MSD'S
SUBSTANCE-FREE (DRUG-FREE) WORKPLACE
PROGRAM ACKNOWLEDGMENT FORM
and
POST-ACCIDENT RESPONSIBILITIES FOR
PERSONNEL WHEN OFF-SITE

I have received, reviewed and understand *MSD's Policy Commitment To A Substance-Free (Drug-Free) Workplace*. I understand the benefits it offers and the requirements it imposes. I understand and agree that even more detail of the Company's program can be found in the *MSD's Operational Guidelines To A Substance-Free (Drug-Free) Workplace Program*. I acknowledge that I have been given access and the opportunity to review the *MSD's Operational Guidelines To A Substance-Free (Drug-Free) Workplace Program*, and that the Program Administrator, identified in the *Policy Commitment*, can further assist me with any questions or concerns I have about this program.

I also understand and agree that I must comply with the program as a condition of my employment with the Company, and that any violation of the program and/or my failure to comply with any aspect of the program may be a basis for corrective action, including termination of my employment. The termination notice will indicate "misconduct–rule violation" as the reason and may affect my ability to receive unemployment benefits.

I further understand and agree that nothing in the commitment or the program's operational guidelines -- or in any oral representations by the Company about or related to its implementation or enforcement of the program -- constitutes an express or implied contract of employment, or any promise upon which I can rely. All employment relationships with the Company remain "at will."

In addition, I understand that I am responsible for being drug and/or alcohol tested following a work-related accident as defined in this program even if I am off-site at the time of the accident. In such circumstances, I am responsible to contact my supervisor or another management person from the Company to arrange for the testing. I agree to sign any authorization required by the Company and/or the testing laboratory to permit such testing to be conducted and to permit disclosure of the test results to the Company.

If I seek medical attention on my own for an injury that occurred during work hours, I am responsible to notify the Company within two hours of arrival at the medical facility. (That is not two hours after treatment – but two hours after arrival to the facility for treatment.)

Any delay in promptly informing the Company of my involvement in an accident may be deemed a refusal to test if the delay is not supported by a credible and justified explanation.

I also understand that failure to comply with such post-accident testing may be deemed either a refusal to be tested or a positive drug and alcohol test under MSD's Drug-Free Workplace Program, and that I may thereafter be subject to corrective action under the Company's program.

I understand that my refusal to have a post-accident test or if my post-accident test is positive as defined by this Program, my right to receive workers' compensation benefits for any injuries sustained in that accident may be negatively affected.

_____	_____
Date	Employee's Signature
_____	_____
Representative for MSD	Employee's Name (printed)
	_____
	Parent's or Guardian's Signature (for employees under 18 years of age)

(A copy of this signed form is to be provided to the employee.)

MSD'S
SUBSTANCE ABUSE (DRUG-FREE)
TESTING CONSENT/AUTHORIZATION FORM

I understand that the Substance-Free (Drug-Free) Workplace Program establishes conditions under which I may be required to provide a urine, breath, saliva and/or blood sample for drug and/or alcohol testing. Should this occur, I hereby consent to such testing. I further authorize the testing laboratory to release my test results to designated managers and/or the outside reviewing agent(s) chosen by the company.

Although contractual guidelines or collective bargaining agreements may provide other limitations, I am here informed of the limitations associated with Federal health care privacy rules. That is, if the person or entity who receives my protected health information is not covered by the Federal health care privacy regulations, my personal health information that was disclosed will no longer be protected and may be re-disclosed to another person or entity according to the Federal health care privacy rules.

Should there be a positive test result, I understand that I may be given the opportunity to explain and give information about the drugs found to be in my system to a Medical Review Officer ("MRO"). This MRO may ask me to provide, and I agree to provide, information about any legal non-prescription drugs and other drugs for which I have a prescription that I take routinely or have taken within the last thirty (30) days.

I understand that

- any communication I may have with the collection site personnel, testing laboratories or MRO does not create or imply any form of doctor/patient relationship.
- the testing laboratory and the MRO referenced herein may receive compensation for providing the test results to my employer.
- I may inspect or copy the information disclosed under this authorization and that such information may be automatically provided to me but at a minimum, will also be provided to me by MSD upon my written request.
- if I am terminated as a result of a violation of this Program, my termination will be deemed "misconduct - rule violation" and may affect my ability to receive unemployment benefits.
- my refusal to have a post-accident test or if my post-accident test is positive as defined by this Program, my right to receive workers' compensation benefits for any injuries sustained in that accident may be negatively affected.

I also understand and agree that I must sign this Consent and Authorization as a condition of my employment or participation on an MSD job. My refusal to sign it may be a basis for being denied access to, being barred, being asked to leave immediately from the workplace or the job, and may include termination of my employment.

On the other hand, my refusal to sign this Authorization will not affect my ability to obtain health care treatment from the testing laboratory (if applicable), payment for this treatment, or my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying Privacy Officer of the testing laboratory referenced above, except to the extent that the testing laboratory has taken action in reliance upon the authorization.

This authorization expires when my employment with MSD or the MSD job for which this Consent is being applied ends.

_____ _____

Employee Signature Date Witness Signature Date

_____

Employee Name (print)

_____

Parent's or Guardian's Signature
(for employees under 18 years of age)

(A copy of this signed form is to be provided to the employee.)

FORM D-3

REASONABLE SUSPICION OBSERVATION CHECKLIST

STRICTLY CONFIDENTIAL

Location and Address	
Employee	
Name/Telephone, Supervisor	
Name of Company Witness	
Other Witnesses	

DIRECTIONS

[ ] Complete this checklist when an incident has occurred that provides reasonable suspicion that an employee is in violation of the Company's Substance-Free (Drug-Free) Workplace Program.

[ ] Check each indicator that leads you to believe that the employee is in violation of the Company's program.

[ ] Specify date(s) of observation(s) and indicate who else witnessed the incident (if applicable).

[ ] List any additional behaviors/circumstances not included on the checklist.

A. PHYSICAL INDICATORS (Check and Date all that apply)

INDICATOR	DATE (S), WITNESSES (if appropriate)
OVERALL	
[ ] disheveled appearance	
[ ] drastic changes in appearance after breaks	
SKIN	
[ ] unusually pale	
[ ] unusually flushed	
[ ] sores or needle marks	
ODOR	
[ ] smell of alcohol	
[ ] smell of illegal drugs	
EYES	
[ ] bloodshot	
[ ] dilated pupils	
[ ] pinpoint pupils	
[ ] blank stare/expression	
[ ] sunglasses worn at inappropriate times	
NOSE/MOUTH	
[ ] dry mouth	
[ ] excessive yawning	
[ ] difficulty/irregular breathing/swallowing	
[ ] unusual sneezing/congestion	
MOTOR SKILLS	
[ ] swaying, staggering, falling	
WALKING AND TURNING	
[ ] swaying, arms raised for support, stumbling, falling, reaching for support	
MISCELLANEOUS	
[ ] shaking, tremoring, twitching	
[ ] excessive perspiration	
[ ] other – explain	

B. BEHAVIORAL INDICATORS (Check and Date all that apply)

INDICATOR	DATE(S)
MOOD	
[ ] verbally abusive	
[ ] physically abusive	
[ ] extremely aggressive	
[ ] belligerent	
[ ] giddy	
[ ] moody	
SPEECH	
[ ] slurred	
[ ] fragmented	
[ ] changes in volume	
[ ] changes in speed	
FOCUS	
[ ] appears disoriented	
[ ] unable to focus on work	
COOPERATION	
[ ] resistive	
[ ] insubordinate	
MISCELLANEOUS	
[ ] confession about alcohol/drug use	
[ ] report of use from another employee	
[ ] possession of substance looking like drug	
[ ] possession of drug paraphernalia	
[ ] changes in energy level	
[ ] other – explain	

C. JOB PERFORMANCE PATTERNS (Check and Date all that Apply)

INDICATOR	DATE (S), WITNESSES (if appropriate)
ABSENTEEISM	
[ ] multiple unauthorized leaves	
[ ] excessive sick leaves	
[ ] frequent Monday/Friday, after pay-day, after holiday absences	
[ ] excessive tardiness	
[ ] leaving work early	
[ ] unbelievable excuses for absences	
[ ] frequent, unscheduled short absences	
ON-THE-JOB ABSENTEEISM	
[ ] continued absences from work site	
[ ] long coffee or smoking breaks	
[ ] physical illness on the job	
[ ] frequent trips to the bathroom	
[ ] sleeping or dozing on the job	
HIGH ACCIDENT RATE	
[ ] accidents on the job	
[ ] accidents off the job (affecting performance)	
DIFFICULTY CONCENTRATING	
[ ] work requires greater effort	
[ ] job takes more time	
CONFUSION	
[ ] difficulty recalling instruction/directions	
[ ] difficulty handling complex tasks	
[ ] difficulty recalling own mistakes	
SPASMODIC WORK PATTERNS	
[ ] alternate periods of high/low productivity	
[ ] submission of incomplete reports/data	
MOTIVATION	
[ ] appears less committed to the job	
[ ] appears unconcerned about quantity/quality	
[ ] frequently expresses job dissatisfaction	
REDUCED JOB KNOWLEDGE/ TECHNICAL SKILLS	
[ ] does not know work tasks	
[ ] frequently needs instruction	
[ ] does not use equipment properly	
[ ] unable to work independently	
POOR RELATIONSHIPS ON THE JOB	
[ ] overreacts to real/imagined criticism	
[ ] wide mood swings	
[ ] borrows money from co-workers	
[ ] unreasonable resentments	
[ ] unable to work with others	
[ ] complaints from/about co-workers	
[ ] avoids professional activities/trainings	

ADDITIONAL OBSERVATIONS/CIRCUMSTANCES AND ACTIONS TAKEN (use additional sheets as needed):

_____ _____

Signature - Supervisor #1 Date

_____ _____

Witness Date

MSD'S
DRUG/ALCOHOL TESTING
COLLECTION SITE INSTRUCTION FORM

Referring supervisor/manager: Complete this form when sending an applicant/employee for drug/alcohol testing. Please print all information. Remember, the employee should be directed to have a picture I.D. with him/her for inspection by the Collection Site and he/she is to report there immediately. Advise the employee where to go following the collection process and how transportation should occur.

Applicant/employee: Present this form, the laboratory's Chain of Custody Form and/or the drug testing collection kit as applicable and a valid picture identification to collection site personnel at the time of your arrival at the designated collection site.

DATE: _____ TIME:_____

NAME OF INDIVIDUAL TO BE TESTED: _____

INDIVIDUAL'S TELEPHONE NUMBER - **HOME:** _____**WORK:** _____

INDIVIDUAL'S SOCIAL SECURITY # OR CHAIN OF CUSTODY #: _____

TYPE OF TEST BEING REQUESTED.....

Non-DoT: _____ panel

Split Specimen …….YES or NO

_____Pre-employment **_____Drug**

_____Reasonable Suspicion **_____Drug and _____Alcohol***

_____Post-Accident **_____Drug and/or _____Alcohol***

_____Return from Layoff and Leave of Absence **_____Drug**

_____Random (Systematic Computer-Generated) **_____Drug _____Alcohol***

_____Return-To-Duty after a Program Violation **_____Drug _____Alcohol***

_____Follow-up to Assessment or Treatment **_____Drug and/or _____Alcohol***

_____Owner/Contractor-Required **_____Drug and/or _____Alcohol***

_____Government-Required **_____Drug and/or _____Alcohol***

NAME OF REFERRING MANAGER/SUPERVISOR: _____

WORK TELEPHONE NUMBER: _____

*Alcohol testing may be performed when the situation has been assessed for direct threat and when it is job-related and consistent with business necessity.

REFERENCE LIST OF QUALIFIED ASSESSMENT PROFESSIONALS

(To be completed by the Program Administrator and updated periodically.
Check with the Alcohol Drug Addiction & Mental health Services Board (ADAMH)
or Recovery Services Board serving your County.)

Name:_____

Address:_____

Telephone:_____**FAX:**_____

Notes:_____

_____

Name:_____

Address:_____

Telephone:_____**FAX:**_____

Notes:_____

_____

Name:_____

Address:_____

Telephone:_____**FAX:**_____

Notes:_____

_____

Name:_____

Address:_____

Telephone:_____**FAX:**_____

Notes:_____

_____

I received this document on _____.
Date

_____
Employee's Signature

FORM D-6

MSD'S
POST ACCIDENT
CERTIFICATE OF FITNESS TO RETURN TO DUTY

As required in the Company's Substance-Free (Drug-Free) Workplace Program, I have undergone drug and/or alcohol testing following an accident and am awaiting the results.

I certify that I currently am not suffering any adverse effects from alcohol or any other drugs that would impair my behavior or ability to perform the duties and responsibilities of my job safely and satisfactorily.

I realize that if the results of my post-accident alcohol and/or drug test are positive, I will be found in violation of this program from the time of the accident and administration of the post-accident test and will be subject to "Corrective Action For Violations Of Program" guideline requirements.

_____ _____
Date Employee Signature

_____
Employee Name (printed)

_____ _____
Date MSD Representative Signature

FORM D-7

MSD'S
ASSISTANCE AGREEMENT
(Contingent Participation / Treatment Assistance Agreement)

On this _____ day of _____, _____, the Company and _____(also referred to herein as "I") agree that that in lieu of the Company terminating my employment, I agree to and will comply with the terms and conditions put forth in this agreement. This includes, my acknowledgement that I have sought or will be seeking a chemical dependency assessment, a referral to and/or treatment for alcohol and/or drug abuse. The following conditions will apply:

☐ Assessment has been scheduled. Appointment Date:_____ Appointment Time: _____

☐ You are to make the appointment and report within 48 hours the following:

Counselor's Name: _____ Telephone Number: _____

Appointment Date: _____ Appointment Time: _____

1. I understand and agree that I have violated the Company's Substance-Free (Drug-Free) Workplace Policy. I authorize the designated representative of MSD to share information with the chemical dependency professional about my situation or problem behavior, which may or already has impacted the job.

2. I authorize my assessment/treatment provider to submit to the Company's Program Administrator on a regular basis, and at any other time that the Company requests, proof of attendance and satisfactory compliance with all required sessions and activities of the program. I understand that my attendance may be monitored closely by the Company and that the Company may terminate my employment if I do not attend all sessions and meet all requirements of the program.

3. I am responsible for and will pay for all the costs of my assessment/treatment program which are not covered under the Company's medical benefits plan, other Company-provided services, and/or other medical plan to which I have access.

4. Upon completion of the assessment/treatment program, I agree that I may be asked to supply the Company with a statement from my provider that I have completed all aspects of the program in a satisfactory manner.

5. I understand that I cannot return to work until I have presented the Company with verifiable documentation from the assistance professional that I may to return-to-duty, and I undergo a return-to-duty drug and/or alcohol test and receive a negative result.

6. During the assessment/treatment period and for at least one year following successful completion of the assessment and/or treatment program, I agree and consent to submit to unannounced, "follow-up" testing for illegal drugs and/or alcohol whenever requested to do so by my provider and/or the Company. The frequency and period of time during which I will be subject to follow-up testing will be determined with input from a qualified clinical/treatment professional. I further understand and agree that should I test positive on any such test, refuse to submit to any such test, and/or fail to comply with all sample collection and chain of custody procedures related to any such test, I may be subject to immediate termination from employment.

7. I further understand and agree that while employed by the Company I must meet all of the Company's standards of conduct applicable to other employees, and that the Company may terminate me if the Company determines that I have failed to do so.

8. I agree that I am and will be held to the same job performance and behavior standards as other employees, and that I further understand and agree that I may be subject to termination if I fail to meet job performance and behavior standards or if I relapse at any time during or after my participation in the assessment/treatment program.

9. Other Terms: _____

_____

_____

_____

10. I further understand that failure to comply with any of the above conditions may result in my immediate discharge, and that nothing in this agreement (except for the Company's current decision not to terminate my employment), or any contemporaneous oral or written representations, alters my at-will employment status.

11. I also understand and agree that should the Company terminate my employment pursuant to this agreement, I will be eligible for re-hire -- to a position for which I am then qualified and one for which the Company is seeking applicants – *only* if I can demonstrate, to the Company's satisfaction, that I have, (1) successfully completed (or am satisfactorily participating in) a qualified drug and/or alcohol assessment and any required treatment, and (2) that I am no longer engaged in the illegal use of drugs, or the use of alcohol in a manner which makes me unqualified for the job for which the Company may be seeking applicants. I further understand and agree that should the Company re-hire me, I will consent and be subject to whatever continuing drug and/or alcohol testing the Company deems appropriate.

I hereby knowingly and voluntarily agree to all of the above conditions. I further authorize my assessment/treatment provider to provide the Company with proof of my enrollment, attendance in, and completion of the recommended program. I am also entering into this *Assistance Agreement* of my own free will, after considering its terms, and without duress.

_____ _____

Employee's Name (printed) Supervisor's/Program Manager's Name

_____ _____

Employee's Signature Supervisor's/Program Manager's Signature

_____

MSD Program Administrator

FORM D-8

PROPERTY PROTECTION FORM FOR
MSD'S THIRD PARTY PROVIDERS

With this agreement, _____ representing _____
Name Third Party Provider

acknowledges and agrees that he/she may acquire intimate knowledge and confidential and/or proprietary information as we work together regarding the needs of _____.
Client Company Name

That business information and/or materials of Dee Mason, *Working Partners* ® Systems, Inc. including but not limited to the substance-free (drug-free) workplace policy, operational guidelines, appendices, forms and manual articles are being provided to him/her for review and discussion. He/She understands that this information is proprietary and protected under copyrights by Dee Mason, *Working Partners*® Systems, Inc.

_____ further agrees that *the intimate knowledge, confidential*
Name

information, including the policy, operational guidelines, its appendices or any other proprietary materials or information about or from *Working Partners*® Systems, Inc. ***will not be discussed, shared, copied, reproduced, transmitted and/or distributed to any other entity*** beyond himself/herself without the prior written permission of the appropriate source; Dee Mason, *Working Partners*® Systems, Inc..

Please sign below to indicate that you will comply with this requirement.

_____
NAME Date

_____
Representing - Third Party Provider

POST-ACCIDENT TESTING RESPONSIBILITIES
for PERSONNEL WHEN OFF-SITE

IMPORTANT: IT IS THE RESPONSIBILITY OF **DRIVERS AND OTHER PERSONNEL WHEN OFF-SITE (hereafter called "drivers")** TO IMMEDIATELY REPORT ANY ACCIDENT AND ENSURE THAT A POST-ACCIDENT TEST IS PERFORMED FOLLOWING AN ACCIDENT AS DEFINED IN THE COMPANY'S SUBSTANCE-FREE WORKPLACE PROGRAM.

"Immediately report" means within two hours of admittance to a medical facility whether during or following work for an injury incurred on the job. (That is not two hours after treatment - but two hours after arrival to the facility for treatment.)

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1. WHEN IS A DRUG AND/OR ALCOHOL POST-ACCIDENT TEST REQUIRED?

A drug and/or alcohol test is required after an accident, whenever:

A) there is a fatality ;

B) anyone involved requires medical attention away from the scene of the incident or treatment from a medical professional;

C) there is vehicular and/or equipment damage in apparent excess of **$**1000.00; or

D) there is non-vehicular property damage in apparent excess of $1000.00.

You should assume that a drug <u>and</u> alcohol test is required. Only the Company contact can excuse you from being tested.

IMPORTANT: YOUR REFUSAL TO SUBMIT TO A POST-ACCIDENT DRUG OR ALCOHOL TEST AND/OR IF YOUR TEST IS POSITIVE AS DEFINED BY THIS PROGRAM MAY JEOPARDIZE YOUR OPPORTUNITY FOR WORKERS' COMPENSATION BENEFITS (if applicable).

FURTHERMORE, A REFUSAL OR POSITIVE TEST MAY DISQUALIFY YOU FROM DRIVING A COMPANY VEHICLE OR DRIVING FOR COMPANY BUSINESS AS WELL AS OTHER CORRECTIVE ACTION AS OUTLINED IN THE COMPANY'S PROGRAM.

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2. WHAT MUST YOU DO AFTER AN ACCIDENT WHEN YOU NEED TO BE TESTED?

A) You must <u>remain readily available</u> for testing following the accident. A failure to remain readily available will be treated as a refusal to test.

Any necessary medical treatment will not be delayed and you can leave the scene to get necessary emergency care. However, you must remain readily available for testing.

ALCOHOL TEST: You must provide a breath sample using an authorized EBT as soon as possible, <u>but preferably not more than 4 hours after the accident</u>. You should not consume any alcohol within 4 hours following an accident.

NOTE: A blood test may be administered if a qualifying EBT is not available.

DRUG TEST: You must provide a urine sample for testing as soon as possible, but preferably not later than 8 hours after the accident.

B) If you cannot provide a specimen at the time of the accident, you must provide the necessary authorization for obtaining hospital reports and other documents that would indicate whether there were any drugs or alcohol in your system. (Use the attached hospital authorization form.)

C) A law enforcement official may perform a drug and/or alcohol test on you for their own law enforcement purposes. **The law enforcement tests do not relieve you of your responsibility to be tested under the Company's Substance-Free (Drug-Free) Workplace Program regulations.** However, you should inform the Company if the law enforcement officials have tested you.

3. HOW DO YOU SUBMIT A URINE OR BREATH SAMPLE?

A) Contact the Company's designated representative or the Program Administrator at the number listed below to learn where you must go to submit a sample.

Normally, you will submit a urine sample for drug testing and a breath sample for alcohol.

B) Have a valid form of identification available.

NOTE: Upon notice of a positive test, you may request a re-test. You must make this request within 72 hours after receiving notice of the positive test.

4. WHAT DRUGS WILL I BE TESTED FOR?

You will be tested for an array of drugs stipulated in your Drug-Free Workplace Policy.

*NOTE: MSD reserves the right to expand this list or adjust the cut-off levels stated here in order to mirror additional drug categories that are required at the federal level for mandated employees (e.g. MDMA, etc.). Furthermore, the **Company** reserves the right to require testing for another drug that is not on this list if there is documentable reason to believe that the employee may be under its influence and therefore safety and productivity may be compromised or if the **Company** needs to comply with a contract or regulatory authority.*

5. IF YOU NEED MORE INFORMATION CALL:

COMPANY CONTACT:
Jackie Tangeman, at 937-254-3235

FORM E-3

MSD'S
POST-ACCIDENT
HOSPITAL AUTHORIZATION FORM

Consent and Release of Information

I understand, pursuant to Title 49 CFR 382.303, that I must be tested for drugs and alcohol following an FMCSA reportable accident and/or pursuant to MSD's Substance-Free (Drug-Free) Workplace Program which seeks to meet the requirements of the Ohio Bureau of Workers' Compensation Drug-Free Safety Program, that I must be tested for drugs and alcohol following a qualifying accident (as specified per governing policy.) *I also understand that any necessary medical attention will not be delayed and that I may leave the scene of the accident for the period necessary to obtain assistance in responding to the accident, or to obtain necessary emergency medical care.* However, I will remain readily available to be tested as required.

In the event that I am transported to a hospital and/or I cannot produce a breath, saliva or urine sample of my own volition, I hereby authorize the hospital to release any information, related to the program's testing requirements and necessary to meet the requirements of these regulations and this program such as a toxicity test report, to the designated Company representative. I understand that if the person who receives my protected health information is not covered by the Federal health care privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by the Federal health care privacy rules.

Further, I understand that I may withdraw this authorization but that to not authorize the hospital to release information pertaining to the program's testing requirements, I will be considered refusing to submit to or make myself readily available for a drug and alcohol test as required by DOT-FMCSA and the Company's Drug-Free Workplace Program.

On the other hand, my refusal to sign this authorization will not affect my ability to obtain health care treatment from the testing laboratory, payment for this treatment, or my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that my failure to submit to a drug and/or alcohol test as required by the program or my failure to remain readily available for a test, will be treated as a positive drug and alcohol test and/or failure to comply with the Company's program. I understand that my refusal to have a post-accident test or if my post-accident test is positive as defined in the Company's Program, my right to receive workers' compensation benefits for any injuries sustained in that accident may be negatively affected.

I understand that my signature for the release-of-information cannot be applied beyond 60 days from the date it is signed and that in the event the Company representative needs such records or

information from the hospital, I may be asked to sign a new Post-Accident Hospital Authorization Form for MSD and that failure to do so will be seen as a violation of the Program.

I understand that I may inspect or copy the information disclosed under this authorization and that my request for such should be made in writing.

I understand that the testing laboratory identified by the Company may receive compensation for the use or disclosure of my protected health information.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying the Privacy Officer of the hospital, except to the extent that the testing laboratory has taken action in reliance upon the authorization.

_____	_____
Employee's/Patient's Name (Print)	Employee's/Patient's Signature
_____	_____
Date	Parent's or Guardian's Signature (for employees under 18 years of age) or Person authorized to sign in lieu of the patient/employee
_____	
Witness	

(A copy of this signed form is to be provided to the patient.)

MSD'S
VERIFICATION: FITNESS FOR DUTY
WHILE USING PRESCRIPTION And/Or OVER-THE-COUNTER DRUGS

I verify to the Company that, although I am taking a prescription and/or over-the-counter drug for legitimate medical or health reasons, I am currently fit for duty in my current position and that, if I take the drugs as prescribed and/or directed, I have not experienced any adverse side effects that would pose a risk of harm to me or others in the workplace or in the performance of my job.

If I'm directed to take and/or prescribed any new drug during my employment with the Company, I will discuss any potential adverse side effects pertaining to job performance or safety in the workplace with my prescribing physician, and I will update this verification to the Company as necessary.

_____ _____
Date Employee Signature

_____
Employee Name (printed)

_____ _____
Date MSD Representative Signature