DOT Drug Free Policy Worksheet

You have requested a worksheet in order for your entity to receive a proposal to develop a Drug Free Workplace Policy and/or Forms. You will be sent an engagement letter to confirm the work requested prior to drafting your customized Drug Free Workplace Program. If you have questions contact attorney Tommy Eden, a partner working out of the Constangy, Brooks, Smith & Prophete, LLP offices in Opelika, AL and West Point, GA and a member of the ABA Section of Labor and Employment Law who serves on the Board of Directors for the East Alabama SHRM Chapter. **Contact him at Office: 334-246-2901; Mobile: 205-222-8030; Blog: www.alabamaatwork.com; Website: www.constangy.com. Email: teden@constangy.com.**

This is a fillable PDF. Please fill out this questionnaire and return it via email to teden@constangy.com or fax to 334-521-7017 so that we can provide to you a flat rate quote for your project. Thank you.

1. Name of the Entity as it should appear throughout the Policy & Forms:
   Answer: _____ *****Entity Name*****

2. Abbreviated Name of the Entity as it should appear throughout the Policy & Forms (such as "ATC" rather than "American Trucking Company, Inc."):
   Answer: _____ *****Abbreviated Entity Name*****

3. Type of Entity: (examples - Company, Organization, Agency, League, Association, Corporation, Firm, Group, Department, Practice, Partnership, Enterprise):
   Answer: _____ *****Entity Type*****

4. Mailing Address (include city, state & zip code):
   Answer: _____ *****Address*****

5. Phone number:
   Answer: _____ *****Telephone*****

6. Fax number:
   Answer: _____ *****Telefax*****

7. Title and/or Name of the Entity's "Designated Employer Representative" – (This should be the person in charge of implementing the program, overseeing employee education, arranging for testing, and keeping records of the Entity's compliance with drug-free workplace rules. It is generally the personnel director, administrator, or your Entity's equivalent):

Answer:

***** DER*****

DER's Title: _____

DER's address: _____

DER's Phone: _____

DER'S E-mail: _____

Hours when available: _____

8. Back-up DER: _____

*****Alternate DER*****

Answer:

DER's Title: _____

DER's address: _____

DER's Phone: _____

DER'S E-mail: _____

Hours when available: _____

9. Name of your certified Medical Review Officer (MRO) – (a licensed physician (MD or DO) and who is responsible for receiving and reviewing laboratory results generated by an employer's drug testing program and evaluating medical explanations for certain drug test results):

*****MRO*****

Answer: _____

MRO's Address: _____

MRO's Phone: _____ MRO's Fax: _____

10. EAP Provider (provide all contact information-must have if PHMSA regulated)

Answer: _____

*****EAP*****

_____

11. **Lab Answer: Address:**

***** Lab*****

12. How many DOT covered employees?

Answer: _____

Under what DOT agency(s) regulations do your covered employees work?

13. Do you also want additional state specific "Company Authority" policy? If yes, what state?

Answer: Yes / No _____

State: _____

*****State*****

14. When do you plan to implement the program (date)?

Answer: _____

*****Effective Date*****

15. Alcohol Testing Site(s) & Specimen Collection Site(s):

Answer: _____

16. Substance Abuse Professional (SAP) *****SAP*****

Answer: _____

Address of SAP: _____

SAP Phone: _____

17. Consortium/Third Party Administrator (C/TPA) *****TPA*****

Answer:_____

Address: _____

Phone: _____

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