Exhibit B

CDS Services, Inc.

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

EASTERN MISSOURI LABORERS DISTRICT COUNCIL
SUBSTANCE ABUSE CONSORTIUM POLICY
EMPLOYER/UNION REGISTRATION

Employer/Union Legal Name ____

Street Address ____
(Billing Address - NO PO BOX)

City ______________________________ State _________ Zip _________

Phone Number ( ) ____________________ Fax ( ) ____________________

E-mail Address: ____________________ E-Invoice Address: ____________________
(Address to E-mail invoices)

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 CDS SERVICES, INC. (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

CDS Services, Inc.

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

EASTERN MISSOURI LABORERS DISTRICT COUNCIL
SUBSTANCE ABUSE CONSORTIUM 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