



Rested Care Management Consortium Program is for random drug and alcohol screening. With your initials and signature, you understand that you as well as any other employees are at equal risk for being selected to have a drug and/or alcohol screening according to the Federal Motor Carrier Safety Administration, FMCSA. The percentages for screening are regulated and determined by the FMCSA.

The "I" here is the company's DER, Designated Employer Rep, or Owner.

Please read the following statements carefully, initialing, and providing a signature that acknowledges that you understand each statement and all the information.

\_\_\_\_\_ I understand that this is for the benefit of the company and before joining any random testing pool the employees must have a pre-employment Urine Drug Screening or provide proof of enrollment from my current or previous consortium program. The proof must show that they were eligible for drug screening within the last 30 days from today.

\_\_\_\_\_ I understand that by joining Rested Care Management, LLC's Consortium Program, my business is subject to random testing that is determined through the random generation software used by Rested Care Management, LLC.

\_\_\_\_\_ I understand that it is left up to me to notify Rested Care Management, LLC once an employee is no longer employed either voluntarily or termination of employment. I should also provide a quarterly updated employee list.

\_\_\_\_\_ I understand once the employees have been notified, they should report to the collection site immediately and must arrive within one hour.

\_\_\_\_\_ I understand that if one or more employees fail to have the randomly selected tests performed or fail to report to a collection site immediately after notification, the company will be removed from the random testing program and additional fees will apply.

\_\_\_\_\_ Any fees made today are non-refundable, provides consortium services for the rolling calendar year. I understand if I would like to continue with Rested Care Management, LLC I must renew and submit payment by the end of the month for the following year.

\_\_\_\_\_ I understand that if I fail to contact/provide payment to Rested Care Management, LLC for any services my company will be removed from the consortium program.

\_\_\_\_\_ If I am removed from the consortium program for non-compliance, Rested Care Management, LLC reserves the right to charge an additional fee or refuse readmission into our program.

I have read and understand all information in this contract and agree to pay the service fee contracted.

\_\_\_\_\_ Date