



THE NEWPORT ALLIANCE

A Division of Newport Hospital

UNITED STATES COAST GUARD DRUG TESTING CONSORTIUM

COMPANY REGISTRATION		
COMPANY NAME _____		
MAILING ADDRESS _____		
CITY _____	STATE _____	ZIP _____
TELEPHONE (____) _____		
FAX (____) _____		
DESIGNATED EMPLOYER REPRESENTATIVE _____		
(If possible, list an individual who will not be enrolled in the program)		
ALTERNATE CONTACT PERSON _____		
Do you prefer a VHS training tape ____ or a DVD ____		
Please identify how you wish to receive your drug testing results (Please select one box only).		
<input type="checkbox"/> E-mail (write e-mail address): _____ <input type="checkbox"/> Fax (write fax #): _____		
<u>COAST GUARD REGULATIONS REQUIRE YOU TO LIST YOUR VESSEL NAME AND ID # FOR EACH VESSEL OWNED AND OPERATED:</u>		
1. _____		
2. _____		
3. _____		

MEMBERSHIP FEES

The membership fee is **\$75 per person, per membership year (May – April)**. The fee covers the following services: **drug tests, supervisor training tape, nation-wide collection site setup and management, random selection/notification, SAMHSA-certified laboratories, medical review services, blind sampling, record keeping, and a company membership certificate. Failure to pay invoices upon receipt will result in removal from the program.

*****Periodic drug tests, split specimen testing, litigation packages, MRO testimony, and physicals are not included in this membership. These expenses are the Employer's responsibility.***

AGREEMENT

***This company and/or independent operator agrees to comply with all U.S. Coast Guard's federal regulations pertaining to chemical testing and has a company policy and EAP program in place.
I am aware that all employees must have a negative pre-employment test (or meet the exception) prior to performing safety-sensitive functions and agrees to provide documentation if necessary.***

Signature

Date

INSTRUCTIONS

1. Complete Company Registration and sign/date agreement above.
2. Complete Employee Registration (make additional copies as needed).
3. Return with payment to:

The Newport Alliance
 19 Friendship Street, Suite G-40
 Newport, RI 02840-2200
 (800) 223-2133 / 401-845-1365/ Fax (401) 848-6047
www.newportalliance.org / www.newportalliance@lifespan.org

EMPLOYEE REGISTRATION
UNITED STATES COAST GUARD (MARINE PROGRAM)

INSTRUCTIONS:

1. Fill out the information section below for each person to be covered in the drug-testing consortium.

**IF YOU WISH TO PURCHASE POST ACCIDENT ALCOHOL TESTING KITS (PAKIT) THEY ARE AVAILABLE:
\$8.00 PER KIT _____**

Name: _____ Home Telephone: () _____

Social Security Number: _____ Date of Birth: _____

Name: _____ Home Telephone: () _____

Social Security Number: _____ Date of Birth: _____

Name: _____ Home Telephone: () _____

Social Security Number: _____ Date of Birth: _____

Name: _____ Home Telephone: () _____

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