

Record Establishment

Please use one of the following forms to help SCT establish your records for this program.

If you are the Designated Representative of a Company or Union, please fill out the center section of this brochure. You may then re-fold, seal and mail this information back to the address on the back or Fax the information to 216-587-1586 or send the information in email format to bwood@safetycontrolstech.com.

If you are a designated representative we will verify your information and contact you with a personal website **User Name and Password**.
 If you are a program participant please be sure to sign the last section of the Participant Form.
 We will establish your record as soon as we have confirmation of your previous records.

Thank you for allowing Safety Controls Technology to serve your needs!



*Safety Controls Technology, Inc.
Occupational Health Division—Drug-Free Workplace.*

Substance Abuse Program Union or Management Designated Representative

Last Name: _____

First Name: _____

Middle Name/Initial: _____

Company Name or Union Represented: _____

Position Title _____

Designating Authority _____

Daytime Phone: _____

Address _____

Home Phone () _____

() _____

Call Phone _____

email Address _____

Signature _____

Safety Controls Technology, Inc

Gail Gruesser: President S.A.P.
 Nancy O'Keefe: DFWP Project Manager
 Beth Wood: SIM
 Barbara Merashoff: DFWP Specialist
 Phone: 216-587-3000
 Fax: 216-587-1586
 E-mail: bwood@safetycontrolstech.com

Substance Abuse Program Participant/Employee

Last Name: _____

First Name: _____

Middle Name/Initial: _____

Current Employer: _____

Union Affiliation: _____

Unique Identifier (last 4 digits of Social Security Number)

Daytime Phone: _____

Address _____

Home Phone () _____

() _____

Call Phone _____

Name of most recent DFWP Trainer _____

Date of Training _____

Current Drug-Free Card ID# _____

Exp. date _____

By signing this form I hereby authorize Safety Controls Technology, Inc (SCT) to place this information into an electronic record. This information will be used to provide current and accurate information regarding my participation in the substance abuse program. Certain information may be made available to designated representatives associated with my union and/or employer in accordance with agreements made with my Trade Union and/or Employer.

Signature _____

Printed Full Name _____