DREXEL UNIVERSITY COLLEGE OF MEDICINE

Monitoring Agreement

Acknowledgment of Drexel University's Drug and Alcohol Free Policy and Drug Testing Consent

I understand that while employed at Drexel University College of Medicine (the "College") that I may be subject to alcohol and drug testing in accordance with Drexel University College of Medicine's Drug and Alcohol Free Policy. A positive drug test or refusal to submit to testing may result in disciplinary action up to and including termination.

BY SIGNING THIS DOCUMENT, I INDICATE THAT I HAVE READ, UNDERSTAND, AND AGREE TO DREXEL UNIVERSITY COLLEGE OF MEDICINE'S DRUG AND ALCOHOL FREE POLICY.

THIS DOCUMENT ALSO CONSTITUTES MY CONSENT FOR DRUG OR ALCOHOL TESTING BY A LABORATORY DESIGNATED BY DREXEL UNIVERSITY COLLEGE OF MEDICINE. IT ALSO CONSITITUES CONSENT FOR THE LABORATORY TO RELEASE THE RESULTS OF MY DRUG/ALCOHOL TEST TO EMPLOPYEE HEALTH.

_____ _____

Signature Date

_____

Name (please print)

Monitoring Agreement

General Provisions

I have voluntarily entered into a monitoring agreement with Drexel University College of Medicine. As such, I agree, as a condition of my continued employment at the "College", to abide by the provisions of this contract. I further understand and agree to abide by the specific terms and conditions set forth in this agreement.

The terms and conditions of this contract shall be in force for a minimum period of one year and up to three years as long as I am an employee of the "College." Violation of the terms of this agreement may be cause for immediate dismissal from Drexel University College of Medicine.

I understand and agree to comply with the following criteria. I agree:

1. To notify Employee Health within 72 hours of being prescribed mood-altering substances by a licensed practitioner. I will provide the name, address and phone number of the licensed practitioner prescribing the medication, the nature of the illness or medical condition, the type, strength, dosage, specific directions for the use of the medication and the expected duration of therapy. I authorize the release of my medical records by the licensed practitioner to a representative of the Program when requested.

2. To abstain from the use of any and all illegal controlled substances and any and all over-the-counter medications that contain mood-altering substances.

3. To obtain permission from my treating physician before taking any un-prescribed over-the-counter medications; i.e., antacids, cold remedies, etc.

4. To submit to random or suspicion based drug screens at the request of a "College" manager or Human Resource Professional.

5. To report relapses immediately.

6. To attend a minimum of either _____ (___) Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other approved recovering professional support groups meeting weekly or participate in other counseling activities as determined by my health care provider and recommended treatment. I will submit initialed documentation of attendance to the Executive Director of Human Resources for the "College" monthly.

7. (For healthcare professionals only) To submit copies to Employee Health of any and all reports submitted to any State Recovering Professional Program as required by me in my State Recovering Professional Program contract.

8. To identify the person who is my sponsor/mentor in my state recovering program and agree to have my sponsor/mentor contact Human Resources when requested.

9. Other special conditions: (list all applicable)

_____
Signature of Employee and Date

_____
Print Name of Employee

_____
Signature of Manager/Supervisor and Date

_____
Print Name of Manager/Supervisor

_____
Signature of Executive Director, HR and Date

_____
Print Name of Executive Director, HR