



M.U.S.T. Safety Program Application

1. Company/Organization Name: _____

Address: _____

City _____ State _____ Zip Code _____

2. Does your company/organization employ craft workers? Yes No
 If yes, please list all crafts and contracts to which your company is signatory.

If yes, please list any Labor Management Funds that you contribute into for drug testing and safety training awareness.

(This may entitle your company for coverage or reimbursement for Drug Testing and/or Safety Training for Craft Persons on behalf of your company/organization that funds have been contributed)

3. Does your company/organization belong to a contractor's association? Yes No
 If yes, please provide name of association

4. **Please classify your company/organization**

Contractor	_____	Contractor Association	_____	Owner	_____
Design Professional	_____	Labor Organization	_____	Public/Municipal Organization	_____
M.U.S.T. Member	_____				

5. Requested Participation Date: _____

6. RESPONSIBLE PERSON REGISTRATION

Note: Each Organization to appoint the following positions/responsibilities. The responsible person can hold multiple responsibilities if designated by the organization.

****All fields below must be filled out completely.****

Primary Contact

Note: Primary Contact is the designated individual responsible for administering the M.U.S.T. Safety Program on behalf of the organization. He/She will register employees in the program, complete the online Authorization for sending an employee for a Drug Test, modify site location of employees, delete employees who are no longer with the employer and be the Primary contact responsible for handling confidential information from the Medical Review Officer.

Name _____ Social Security # _____

Position with Company _____ Email: _____

Phone # _____ Fax # _____

Secondary Contact

Note: Secondary Contact is also a designated individual responsible for administering the M.U.S.T Safety Program on behalf of the organization. He/She will register employees in the program, complete the online Authorization for sending an employee for a Drug Test, modify site location of employees, delete employees who are no longer with the employer and is considered a second contact (if the Primary is not available) responsible for handling confidential information from the Medical Review Officer.

Name _____ Social Security # _____

Position with Company _____ Email: _____

Phone # _____ Fax # _____

Report Manager

Note: Report Manager is a designated individual responsible for running reports. He/She will register employees in the program, complete the online Authorization for sending an employee for a Drug Test, update employee site locations and delete employees who are no longer with the employer. Please use another sheet if you would like to authorize additional Report Managers to your account.

Name _____ Social Security # _____

Position with Company _____ Email: _____

Phone # _____ Fax # _____

MUST Office Use Only

			Contact Person
Signatory To:			
Contributes Funds For Safety Training:			
Contributes Funds For Drug Testing:			
Current With Fringe Benefits	Yes	No	
Proctoring Required	Yes	No	
Employees Confirmed	Yes	No	

Date Portal Opened: _____

MUST Signature: _____ Date: _____