EMPLOYMENT ACKNOWLEDGMENT AGREEMENT

I hereby acknowledge that I have received this company's Drug Free Workplace Handbook, which includes the company Drug Free Workplace policy, employee assistance information, a listing of drugs being tested for, common over-the-counter medications which may alter a drug test and educational material on substance abuse. I have also been given the opportunity to voluntarily complete a Medication Disclosure Form.

I freely and voluntarily agree and realize that as part of my employment, I may be subjected to future drug and/or alcohol screens for post-accident, reasonable suspicion, routine fitness-for-duty, return to work, follow-up, and/or random testing at the company's discretion. I understand that a refusal to submit to a blood, urinalysis, hair and/or breath test will result in immediate termination from employment. I understand that a tampered or an adulterated drug and/or alcohol specimen will be considered a refusal to test, resulting in immediate termination. I understand that a confirmed positive drug and/or alcohol test will result in immediate termination of employment, but if I am able to successfully complete substance abuse treatment at my expense, and if a job is still available, I may be given one chance to be rehired, upon a negative return to work drug and/or alcohol test. I understand that I will be subject to the company rehabilitation agreement and I will undergo random follow-up drug and/or alcohol tests for a period of 2 years. I understand that a confirmed positive drug and/or alcohol follow-up test or any violation of the rehabilitation agreement will result in termination of employment.

I agree to voluntarily submit to a blood, urinalysis, hair and/or breath test for drug or alcohol use as part of my ongoing employment, and I release my employer from any liability resulting from my participation in such a screening. I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's workers' compensation law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test under this circumstance will automatically result in forfeiture of my eligibility for medical and indemnity benefits and immediate termination from employment. I understand that a confirmed positive drug and/or alcohol test, a tampered with or an adulterated specimen or a refusal to test may result in forfeiture of unemployment benefits under Florida law.

I hereby give my consent to release the results of my blood urinalysis, hair and/or breath test to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment. By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel/physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administrating the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review Officer.

I also understand that the Drug –Free Workplace policy and related documents are not intended to constitute a contract between this employer and myself.

As an <u>employee</u>, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, and have received a written 60-day notification of this program, if applicable.

_____	_____	____/____/____
Employee Signature	Print Name	Date

As a <u>job applicant</u>, I freely and voluntarily agree to a hair or urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by this company, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

_____	_____	____/____/____
Applicant Signature	Print Name	Date