

ATTACHMENT I

FAX NOTIFICATION

DRUG FREE ALLIANCE PROGRAM

**CONFIDENTIAL MATERIAL INCLUDED IN THIS FAX
Please Give Directly To Designated Representative**

Company:	Fax Number:
Attention:	Company: ScreenSafe, Inc.
Phone:	For Info. Call: (877) 727-3369
Date: Time:	ScreenSafe Fax Number: (815) 846-7208

“**Confidential**” This message is intended only for the use of the individual to whom it is addressed and contains information that is confidential. If the reader of this message is not the intended recipient or the employee responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us immediately by telephone and return the original message to us at the address below via the United States Postal Service.

The attached participant(s) have been selected for random drug testing. You must notify these participants within 24 hours of your receipt of this fax that they have been selected. The Alliance suggests that you notify the selected participants at a time that will allow the testing to be completed during regular working hours. You must write the time and date of notification next to the employee’s name. **Once you notify a participant they will have FOUR (4) hours to complete the test.**

Please remind your participants that they are required to **bring picture identification** with them to the testing facility. **At the testing site they should identify themselves as part of the IBEW /NECA testing pool.** They must retain the testing receipt the facility gives them and return it to you, the designated representative, to provide proof that the participant has complied with the testing request.

For your convenience attached is a list of testing facilities located in your general area. Please make a copy for each participant so they can select the site most convenient for them.

In the event any of the listed participants no longer work for you, are absent from work today, on vacation, out of town, or refuse to comply with this testing request, please note the information on the attached form and fax it back to ScreenSafe, Inc. at 815-846-7208

ATTACHMENT II

(LOGO)

**THIS FORM MUST BE FAXED BACK TO SCREENSAFE, INC.
BY THE END OF THE BUSINESS DAY
815-846-7208**

Contractor: _____

Designated Representative: _____

Phone: _____ **FAX:** _____

PLEASE MAKE SURE TO FAX BACK THIS PAGE TO SCREENSAFE ONCE IT IS FILLED OUT

Please remember to be discreet when notifying members of there testing

Employee's SSN	Employee's Name	U/ S	Date & Time Notified	Reason Not Notified

**Please Enter "U" for Union Member or "S" for Support Person In Above Column.
For Reasons not Notified, please select from the following codes:**

V = VACATION S = SICK

D = DISABILITY

T = Terminated

Thank You

**SEND UPDATED INFORMATION FOR ALL STATUS CHANGES FOR OFFICE STAFF TO
SCREENSAFE**

**INFORMATION NEEDED
NAME, ADDRESS, PHONE NUMBER AND SOCIAL SECURITY NUMBER**

For office use only
Request date

ATTACHMENT III

AUTHORIZATION FORM

**ALLIANCE AUTHORIZATION FOR CONSENT TO DRUG ANALYSIS
AND AUTHORIZATION FOR RELEASE OF RESULTS FOR
“RANDOM TESTING”**

I understand that I am now subject to drug testing under the Drug Free Alliance Program. I have previously received a copy of that Program.

I am knowingly:

- Agreeing to provide an unaltered urine specimen and to cooperate in the collection site’s normal testing procedures;
- Authorizing the collection site to send my urine specimen to the Alliance’s drug testing laboratory;
- Authorizing the Alliance’s lab(s) to analyze my urine specimens for adulteration, dilution and substitution, and for evidence I use(d) amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, PCP, or propoxyphene.
- Authorizing the lab to disclose my test results (and related information) to the Alliance’s Medical Review Officer; and
- Authorizing the Medical Review Officer to disclose my test results (and related information) and cooperation or non-cooperation in testing and medical review evaluation to the Employee’s Assistance Program and to ScreenSafe, Inc., the Program Administrator.

_____	_____
Witness	Print Your Name
_____	_____
Date	Your Signature
_____	_____
Time	Social Security Number

	Telephone Number

	Address

	City, State & Zip Code

This form must be faxed back by the testing lab to ScreenSafe, Inc. at (815) 846-7209

ATTACHMENT IV

(LOGO)

1ST NON-COMPLIANT-EMPLOYER NOTIFICATION

Date

Dear,

This letter is a follow-up to our phone call to inform you that (participant), an employee of (company), Social Security Number (ssn) is currently unavailable for work.

Please inform (participant) that an evaluation needs to be scheduled with the Employee's Assistance Program (EAP), available through said Employee's health insurance plan in order to get back into compliance. (Participant) will be able to return to work once ScreenSafe receives approval from the EAP. Once you inform the participant that they are unavailable, they cannot return to work until ScreenSafe, Inc. provides a copy of the "Release to Work" to you.

If there are any questions or you need further assistance, please contact me at 877-727-3369.

Sincerely,



James F. Heffernan
Administrator

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT V

(LOGO)

1ST NON-COMPLIANT PARTICIPANT NOTIFICATION

Date

First and Last Name

SSN

This is to inform you that you are non-compliant under the Drug Free Alliance.

This is to further inform you of the steps or action you are required to take at this time.

You are required to contact the Employee Assistance Program, (EAP) available through your health insurance plan to schedule an evaluation. The EAP will conduct an evaluation. If you do not attend your scheduled appointment and cooperate fully, you will be in violation of the Alliance Program and subject to the terms of the Drug Free Workplace Policy.

Please remember that you **cannot** return to work until your evaluation process is complete and you have been **PROVIDED A RETURN TO WORK RELEASE BY THE EAP.**

THE INITIAL SERVICES OF THE EAP WILL BE PROVIDED AT NO CHARGE.

If the EAP decides any additional treatment is needed, this further treatment will not be provided by this program, but will be between you and your health plan provider subject to the plan provisions.

Once you have seen the EAP, if it is determined you can be released to work, ScreenSafe, Inc. will send a release to work notice to your employer as well as to the Referral Office at Local Union 100.

For your information, the Alliance Drug-Free Workplace Policy states all participating employers may reject a referral of a bargaining unit person who tests non-compliant until they have a "Return to Work Release." Therefore, if you choose to not comply with the Policy, all participating employers may reject your referral without owing you any compensation whatsoever until you have seen the Employee's Assistance Program (EAP) and have been released to work.

IF AT ANYTIME YOU FAIL TO COMPLY WITH THIS POLICY, YOU MAY BE SUBJECT TO REMOVAL.

If you would like to have your sample re-tested by a lab of your choice and at your expense, please contact the Program Administrator within five working days of when you are notified of your test results at the below listed number.

If you would like a copy of your results, please contact ScreenSafe, Inc.

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT VI

(LOGO)

2nd NON-COMPLIANT-EMPLOYER NOTIFICATION

Date

Dear,

This letter is a follow-up to our phone call to inform you that (participant), a bargaining unit employee of (company), Social Security Number (ssn) is currently unavailable for work.

Please inform (participant) that an evaluation needs to be scheduled with the Employee's Assistance Program (EAP), available through the employee's health insurance plan) in order to get back into compliance. (Participant) will be able to return to work once ScreenSafe receives approval from the EAP. Once you inform the participant that they are unavailable, neither you nor any other participating employer is required to accept a referral of said employee until ScreenSafe, Inc. provides a copy of the "Release to Work" .

If there are any questions or you need further assistance, please contact me at 877-727-3369

Sincerely,



James F. Heffernan
Administrator

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT VII

(LOGO)

2nd NON-COMPLIANT PARTICIPANT NOTIFICATION

Date

First and Last Name

SSN

This is to inform you that you are non-compliant for the second time within a two year period under the Drug Free Alliance

This is to further inform you of the steps or action you are required to take at this time.

You are required to contact the Employee Assistance Program, (EAP) available through your health insurance plan to schedule an evaluation. The EAP will conduct an evaluation. If you do not attend your scheduled appointment and cooperate fully, you will be in violation of the Alliance Program and subject to the terms of the Drug Free Workplace Policy.

*Please note that you are suspended from employment. No participating employer is required to accept your referral until your evaluation process is complete, you have finished any specified treatments or education programs and you have been **PROVIDED A RETURN TO WORK RELEASE BY THE EAP.***

THE INITIAL SERVICES OF THE EAP WILL BE PROVIDED AT NO CHARGE.

If the EAP decides any additional treatment is needed, this further treatment will not be provided by this program, but will be between you and your health plan provider subject to the plan provisions.

Once you have seen the EAP, if it is determined you can be released to work, ScreenSafe, Inc. will send a release to work notice to your employer as well as to the Referral Office at Local Union 100.

For your information, the Alliance Drug-Free Workplace Policy states all participating employers may reject without any compensation whatsoever a bargaining unit person who tests non-compliant unless they have a "Return to Work Release." Therefore, if you are covered by a collective bargaining agreement and choose to not comply with the Policy, all participating employers will be able to reject your referral until you have seen the Employee's Assistance Program (EAP) and have been released to work.

IF AT ANYTIME YOU FAIL TO COMPLY WITH THIS POLICY, YOU MAY BE SUBJECT TO REMOVAL.

If you would like to have your sample re-tested by a lab of your choice and at your expense, please contact the Program Administrator within five working days of when you are notified of your test results at the below listed number.

If you would like a copy of your results, please contact ScreenSafe, Inc.

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT VIII

LAST CHANCE AGREEMENT

Alliance Last Chance Agreement

I, (employee’s name), am not in compliance with the Drug-Free Alliance Workplace Program.

I acknowledge and agree that in order to remain eligible for employment with any participating employer, I must enter into this Last Chance Agreement. By signing this Agreement, I accept and agree to the following terms and conditions, which will govern my continued eligibility for employment:

1. I will follow all requirements and recommendations by the professionals who have evaluated me. This includes at a minimum, the following:
 - a. Strict compliance with all treatment recommendations
 - b. Complete abstention from all controlled substances, including alcohol, except in accordance with a written authorization of a licensed physician who has been advised in advance of my treatment for substance abuse and has reviewed any prescription in advance with my substance abuse counselor, and
 - c. Regular attendance at required or recommended aftercare programs.
2. I authorize the Administrator and the Member/Employee Assistance Program (MAP/EAP) to communicate with each other concerning all treatment and aftercare program requirements, my non-compliance or compliance with those requirements and to confer with them about my progress. I agree to sign and not revoke any medical release consent forms to allow those information exchanges.
3. *For a period of one year from the date of my return to work, I agree to submit to testing to detect the presence or use of drugs and/or alcohol on at least a monthly basis.*
2. I understand and agree that this agreement does not guarantee me any employment or compensation for any period of time, nor does it provide me any benefit over and above the program or Collective Bargaining Agreement.
3. I understand and agree that if I test positive for controlled substances not taken under the supervision of a licensed healthcare professional or alcohol during the next two years, or if I am declared by the Administrator of the Drug-Free Alliance Workplace Program to be in noncompliance with the Program for any reason, that I will be immediately terminated from employment and if I am covered by a collective bargaining agreement, then all participating employers may reject my referral without any compensation to me whatsoever until I have satisfactorily completed a substance abuse treatment program and I am otherwise found to be in compliance with the Alliance Drug-Free Workplace Program by the Administrator.

Dated this ____ day of _____, 20??. Witnessed this ____ day of _____ 20??.

By: 
Alliance Representative

By: _____
Employee/Member

By: _____
Contractor Representative/Union Representative

ATTACHMENT IX

**(LOGO)
REFERRAL REJECTION RIGHT NOTIFICATION**

CONFIDENTIAL

TO: (Referral)
FROM: ScreenSafe Inc.
DATE:
RE: Employee Status

The following members may be rejected by all participating employers without compensation to them:

NAME	SSN

They are currently not in compliance with the Drug-Free Alliance Workplace Program. The participant must contact the Administrator of the Alliance Program to initiate action intended to restore compliance. If this participant should come to the Referral Hall, please inform them that all participating employers may reject their referral until they have satisfied the requirements set forth in the Alliance Policy.

We will contact you as soon as this member is again eligible for the regular referral system.

ATTACHMENT X

(LOGO)
NON-COMPLIANT EMPLOYER LETTER

Date

(Employer)
(Attn: Designated Rep)
(ADDRESS)

RE: EMPLOYEE'S NAME AND SS#

Dear (Designated Rep):

This letter is to inform you that (participant name) is non-compliant with the Alliance Drug-Free Workplace Policy.

Under the terms of the Policy, (see page 6), bargaining unit participants who are non-compliant with the program are to be removed from active duty. They may not return to work until they have been evaluated by the Employee's Assistance Program, (EAP) available through their health insurance plan) and have completed the specified treatment or education program and obtained a return to work release.

Participants may elect not to utilize the EAP. Those who choose not to utilize EAP are required to wait 30 days from the date of their initial contact with ScreenSafe, Inc. before being allowed to test again. During this thirty (30) day waiting period, participating employers may reject a referral of said bargaining unit participant.

ScreenSafe, Inc. will notify you when (participant) is compliant with the Drug-Free Workplace Program.

If you have any questions, please contact me at 1-877-727-3369

Sincerely,

James F. Heffernan
Administrator

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT XI

(LOGO)

NON-COMPLIANT PARTICIPANT - EAP

Date

Dear,

This is to inform you that you are not in compliance with the Drug Free Alliance. You have chosen either not to utilize the EAP or follow the EAP's specified treatment or education program: therefore, you are required to wait 30 days from the date of your initial contact with ScreenSafe, Inc. before being allowed to test again.

If you are covered by a collective bargaining agreement, then during this 30-day waiting period, the contractor must suspend you from active employment and all participating employers may reject your referral without any compensation to you whatsoever.

Once you have satisfied the requirements of the program, which includes another drug test that has an acceptable result, a "Return to Work Release" will be provided to your employer. If you are covered by a collective bargaining agreement, then this information will also be provided to the Referral Hall at Local Union 100.

If you would like to return to work, you must contact the Employee's Assistance Program (EAP), available through your health insurance plan to schedule an evaluation. The EAP will make the determination when you can be returned to work. While working with the EAP, you must attend your scheduled appointments and cooperate fully in order to stay in compliance with the Drug-Free Alliance Program.

Respectfully,



James F. Heffernan
Administrator

ADD NAME AND PHONE NUMBER FOR EACH OF THE THREE HMOS AT BOTTOM OF NOTICE

ATTACHMENT XII

(LOGO)

1st NON-COMPLIANT-FAILED TO TEST

Date

Dear,

This is to inform you that you are not in compliance with the Drug Free Alliance because you did not take your drug screen in the allotted time as outlined in the policy book. Therefore, if you are covered by a collective bargaining agreement, then all participating employers may reject your referral without any compensation to you whatsoever until one of the following occurs:

Contact the Employee Assistance Program (EAP), available through your health insurance plan to schedule an evaluation. You must attend your scheduled appointments and cooperate fully, subject to the terms of the Drug Free Workplace Policy.

If you choose not to utilize the EAP, you are required to wait 30 days from the date of your initial contact with ScreenSafe, Inc. before being allowed to test again. During this 30-day waiting period, the contractor is required to remove you from active employment and all participating employers may reject your referral without any compensation to you whatsoever. Please remember that all participating employers may reject your referral without paying you any compensation whatsoever until your evaluation process is complete and the EAP has released you to work or you have waited the thirty (30) day period and your test has an acceptable result. At that time, ScreenSafe will send a "Return to Work Release" statement to the Designated Representative at your company and to the Local Union 100 Referral Office.

If you have any questions, please call ScreenSafe, Inc. at 877-727-3369

Respectfully,



James F. Heffernan
Administrator

ATTACHMENT XIII

(LOGO)

RETURN TO WORK RELEASE

Return to Work Release

Participant Name:

Social Security Number:

Company:

Designated Representative:

Date:

The above participant has satisfied the requirements of the Drug-Free Alliance program and if covered by a collective bargaining agreement, then he/she is eligible for the regular referral program.

ATTACHMENT XIV

(LOGO)

REFERRAL AVAILABLE NOTIFICATION

CONFIDENTIAL

TO:

FROM: ScreenSafe Inc.

DATE:

RE: Employee Status

This is to inform you that the following members are available for regular referral to participating employers:

NAME	SSN/IBEW Card #

ATTACHMENT XV

REASONABLE SUSPICION TESTING **Guidelines for Reasonable Suspicion Testing**

Under the terms of the Drug Free Alliance Program, an individual may be tested if one of the following applies:

- There is a reasonable suspicion that someone is under the influence of an alcoholic beverage or an illegal substance.
 - There has been an on the job recordable incident as defined by OSHA
- 1) Do not assume that observed impairment means that the individual is under the influence of an illegal or controlled substance.
 - 2) Do not diagnose the employee's behavior. Remember, you are not a doctor or counselor.
 - 3) Do assess impaired performance/actions, not the reasons behind them.
 - 4) Do use the attached evaluation form to help assess the participant's impairment.
 - 5) The participant's immediate supervisor or other company representative should observe the person and subsequently complete the evaluation form.
 - 6) For every observation made, use a separate reasonable suspicion evaluation form.
 - 7) Be as discreet as feasible. Remove the participant from the workplace and escort the person to your office or another private area.
 - 8) Inform the participant that under the terms of the Drug Free Alliance Program, he/she may be required to test.
 - 9) If after the interview, you believe a test is warranted, inform the participant they are being required to test.
 - 10) Take the participant to a designated collection site.
 - 11) After testing, provide the participant with transportation home or to another safe place.
 - 12) The results will be reported to the Administrator at ScreenSafe and to the designated representative within 24 to 48 hours.

ATTACHMENT XVI

REASONABLE SUSPICION TESTING

ALLIANCE AUTHORIZATION FOR CONSENT TO DRUG AND ALCOHOL ANALYSIS AND AUTHORIZATION FOR RELEASE OF RESULTS FOR “REASONABLE SUSPICION TESTING”

I understand that I am now subject to drug and/or alcohol testing under the Drug Free Alliance Program. I have previously received a copy of that Program and an explanation of my rights and duties under it. I am knowingly:

- Agreeing to provide unaltered urine, breath, blood, hair or saliva specimens and to cooperate in the collection site’s procedures;
- Authorizing the collection site to test my breath, blood or saliva specimens for their alcohol concentration and to disclose my alcohol test results to the Administrator at ScreenSafe, Inc., the Employee’s Assistance Program, and the Medical Review Officer;
- Authorizing the collection site to send my specimen to the Alliance’s drug testing laboratory;
- Authorizing the Alliance’s lab(s) to analyze my specimens for adulteration, dilution and substitution, and for evidence I use (d) amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, PCP or propoxyphene.
- Authorizing the lab to disclose my test results (and related information) to the Alliance’s Medical Review Officer; and
- Authorizing the Medical Review Officer to disclose my test results (and related information) and cooperation or non-cooperation in testing and medical review evaluation to the Employee’s Assistance Program and the Administrator at ScreenSafe, Inc.

Witness

Your Signature

Date

Social Security Number

Time

Telephone Number

Address

City, State & zip code

Please bring this form to the collection site. After it is signed, the Employer’s designated representative must fax this form back to the Administrator at ScreenSafe, Inc. at the number listed below.

ATTACHMENT XVII

REASONABLE SUSPICION TESTING

Reasonable Suspicion Evaluation Form

Incident/Behavior/Performance Report

Use this form to record any incidents, work place performance or work place behavior problems.

Name of observed participant: _____

Date; _____ Job Site; _____

Name of Company Observer: _____

Check all those indicators or cues observed in the work place.

Primary Indicators

Behavior

slurred speech Yes ___ No ___
confused speech Yes ___ No ___
tremors/shakes Yes ___ No ___

Mood

sudden mood changes Yes ___ No ___
isolating Yes ___ No ___
extreme nervousness Yes ___ No ___
belligerent Yes ___ No ___
aggressive Yes ___ No ___
unusually quiet Yes ___ No ___
unusually talkative Yes ___ No ___

Secondary Indicators

Appearance

glassy eyes Yes ___ No ___
blank stare Yes ___ No ___
bloodshot eyes Yes ___ No ___
flushed face Yes ___ No ___
marijuana smell Yes ___ No ___
altered appearance Yes ___ No ___
alcohol smell Yes ___ No ___

Vigilance /Performance

confused Yes ___ No ___
disoriented Yes ___ No ___
drowsiness Yes ___ No ___
sleeping Yes ___ No ___
hearing things Yes ___ No ___
seeing things Yes ___ No ___
blackouts Yes ___ No ___

staggering Yes ___ No ___
poor coordination Yes ___ No ___

ATTACHMENT XVIII

REASONABLE SUSPICION TESTING

Reasonable Suspicion Evaluation Form (side two)

Describe the incident in detail.

If additional space is needed, please use another page.

Please list all witnesses to the behavior or incident.

Did you discuss the incident and/or behavior with the employee? Yes _____ No _____

Remarks:

Signature of Observer _____ Date: _____

Signature of Designated Representative _____ Date: _____

Signature of Employee _____ Date: _____

Signature of Union Representative _____ Date: _____

ATTACHMENT XIX

REASONABLE SUSPICION TESTING

DO'S AND DON'TS FOR DEALING WITH SUSPECTED SUBSTANCE ABUSE

DO

- Do Focus on job performance ONLY.
- Do Remain consistent in applying your company's policy.
- Do Support what you say with objective observations of behavior.
- Do Stay consistent in your use of job standards and job expectations.
- Do Act in a calm, objective manner.
- Do Keep any conversation or action taken with an employee as private as possible.
- Do Discuss an employee's suspected problems only on a need to know basis.

DON'T

- Don't Ignore troubled employees and hope that the problem will go away.
- Don't Try to diagnose the problem.
- Don't Play counselor.
- Don't Moralize.
- Don't Be misled by an employee's sympathy-evoking tactics.
- Don't Cover up for an employee.
- Don't Allow exceptions for one employee and deny exceptions to another.
- Don't Publicly confront or take disciplinary action against an employee suspected of substance abuse.
- Don't Lose your temper, get emotional, or use generalizations when confronting an employee.

ATTACHMENT XX

RETEST OF ORIGINAL SPECIMEN

When a person tests positive under the Drug Free Alliance, he/she has the right to request a confirmation of the **original** specimen. If this is what you choose to do, please follow these guidelines.

- Call the Program Administrator at (877) 727-3369 and request a retest of your original specimen within five days of this notice.

- You are required to pay for the test in advance. Please send a Certified Check or Money Order via Certified Mail, made out to ScreenSafe, Inc. in the amount of \$200.00 to the address listed below. If the result of the retest is negative, you will be refunded the amount of the check and the cost of the mailing.

Copies of the results of the retest will be sent to the Alliance, the Program Administrator and to you.

Administered by ScreenSafe Inc.
P.O. Box 2189 Joliet, IL 60434 Phone 877-727-3369 Fax 815-846-7208

(LOGO)

Employee Registration Form

PLEASE PRINT

There should be one form for each person in your company who works 20 hours or more a week and is not a member of IBEW Local 100) or any other bargaining unit. Please note that there is a \$55.00 set up fee for each non-bargaining unit employee participating in the program and that the monthly cost thereafter is \$2.50 per non-bargaining unit employee per month. It is the responsibility of the individual employer to establish rules and regulations regarding testing of non-bargaining unit participating employees.

COMPANY NAME: _____

EMPLOYEE NAME: _____
FIRST MIDDLE INITIAL LAST

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____

CITY: _____

STATE: _____ **ZIP CODE:** _____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

CELL PHONE NUMBER: _____

PAGER NUMBER: _____

(LOGO)

Form to Designate Representatives

The below named individuals have been selected to act as representatives from our company for the (INDUSTRY & PROGRAM NAME).

As per the Administrative Rules, we have designated two representatives.

For reasons of confidentiality and privacy only these two individuals will handle all confidential correspondence from ScreenSafe in regards to this program.

PLEASE PRINT LEGIBLY:

COMPANY NAME: (please fill in) _____

Representative Name

Representative Name

Phone Number and Extension

Phone Number and Extension

Fax Number

Fax Number

Cell Phone Number

Cell Phone Number

Please return this form to ScreenSafe, Inc.

Administered by ScreenSafe Inc.

P.O. Box 2189 Joliet, IL 60434 Phone 877-727-3369 Fax 815-846-7208