Associated Beer Distributors of Illinois / Mid-West Truckers Association, Inc.

EMPLOYEE ACTION FORM ******** FOR CDL DRIVERS ********

Employer Name: ______________________ Member No.: __________

Contact Person 1: ______________________ Phone No.: __________

Contact Person 2: ______________________ Phone No.: __________

Address: ______________________

City: ______________ State: ______ Zip: __________

☐ **By checking this box, I certify the driver(s) I am adding to my program has signed and received a copy of the Drug and Alcohol Abuse Policy & Attachments A and B (if applicable) and G, and I have the paperwork on file. A pre-employment test is required unless you receive the Attachment B completed by the previous employer confirming he has been in another regulated FMCSA drug & alcohol program in the last 30 days.**

Signature of contact person: ______________________

Please ADD the following to our Drug & Alcohol Testing Program effective: __________

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Name: ______________ SS#: __________ **Date of Birth:** __________
CDL #: ______________ **State Issued:** ______ **Class:** ______

Please REMOVE the following to our Drug & Alcohol Testing Program effective: __________

Name: ______________ **Social Security Number:** __________

Name: ______________ **Social Security Number:** __________

Name: ______________ **Social Security Number:** __________

Name: ______________ **Social Security Number:** __________

Name: ______________ **Social Security Number:** __________

Signature of contact person: ______________________

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(MTA) Attachment X