

# CHEMICAL TESTING PROGRAM AUDIT FORM (A)

Vessel Name: \_\_\_\_\_ Official Number: \_\_\_\_\_

Name of Person in Charge of the vessel: \_\_\_\_\_ / \_\_\_\_\_  
Write / Sign

1. Does the company have a Pre-employment drug-testing program?  
(46 CFR 16.210) YES NO
  
2. Does the company have an Employee Assistance Program?  
(46 CFR 16.401) YES NO
  
3. Does the company have a random drug-testing program?  
(46 CFR 16.230) YES NO
  
4. Does the company use a Consortium or third party to administer  
their Program? YES NO

If YES, Supply the name and phone number of the Consortium:

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I have asked these questions to the above individual and in my opinion the company  
this vessel is operated by DOES / DOES NOT meet requirement in 46 CFR part 16.

CG-835 Issued YES / NO Activity Number : \_\_\_\_\_

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Signature of CG Inspector date