Lake Erie Charter Boat Association

Drug Consortium Application

Be sure to fill out all the blanks

Please check which applies to you: ○ **Captain** ○ **First Mate**

Your Contact Information

Last Name:	
First Name:	
Date of Birth:	
Street Address:	
City, State, Zip	
Home Phone:	
Cell Phone:	
Email Address:	

DER

Do you have a Designated Employer Representative (DER)?		○ **Yes**	○ **No**
If yes, who is your DER?			
DER Name:		**DER Phone:**	

Identification Numbers

Your Social Security Number:	
Your USCG License Renewal Date:	

Membership in Other Drug Consortiums

Are you currently a member of a maritime drug consortium?		○ **Yes**	○ **No**
If yes, what is the name of the consortium (other than LECBA)?			

I hereby authorize LECBA to store my drug records.

Signature: _____ **Date:** _____

Payment of $100 is required by DEC 31 of the current year to stay current with USCG requirements. Make checks payable to LECBA and mail the check and this form to the address below. If you have any questions concerning this drug application or our drug program, please call me at 419-732-2670.

Sandee Abele
245 N. Worthy
Lakeside, OH 43440
419-732-2670
abele@roadrunner.com