



**STATEMENT OF COMMISSIONER GARY BETTMAN
REGARDING NHL/NHLPA PERFORMANCE ENHANCING
SUBSTANCES PROGRAM AND S. 1114 AND S. 1334**

**SUBMITTED SEPTEMBER 26, 2005 IN CONNECTION
WITH TESTIMONY ON SEPTEMBER 28, 2005**

SUMMARY OF STATEMENT OF NHL COMMISSIONER GARY BETTMAN
REGARDING NHL/NHLPA PERFORMANCE ENHANCING
SUBSTANCES PROGRAM AND S. 1114 AND S. 1334

- The public is entitled to have confidence in the integrity of competition in all professional sports, and to watch professional athletes compete free of the influence of performance enhancing drugs. We therefore support the requirement that professional sports leagues conduct mandatory testing on athletes for performance enhancing drugs.
- The NHL and its Players' Association have established a Performance Enhancing Substances Program, under which NHL players are subject to up to two, no-notice, random tests during the NHL season for the performance enhancing drugs designated on the WADA out-of-competition list. Positive tests will result in mandatory discipline as follows: twenty (20) game suspension for first offense; sixty (60) game suspension for second offense; permanent suspension for third offense.
- Players have the ability to establish an applicable therapeutic use exemption, a testing error, mistaken use, or the use of a tainted supplement or other product. Annually, players will receive education regarding the Program and prohibited substances.
- Historically, NHL players have not exhibited problems associated with steroid abuse. Over the past ten years, nearly 1,000 NHL players have participated in international competitions, including the Olympics, where they were subject to drug testing under WADA standards. We are aware of only three positive tests for performance enhancing drugs.
- The NHL does not see a need for the proposed legislation as it would relate to the NHL. However, should Congress decide to legislate along the lines of S. 1114 and S. 1334, the NHL's specific comments are as follows:
 - The Director of the Office of National Drug Control Policy shall be responsible for establishing minimum doping control standards for each sport, as well as test distribution plans, testing protocols and adjudication procedures. The Director shall establish the foregoing after consultation with: (1) the National Institute on Drug Abuse; (2) the United States Department of Transportation; (3) USADA; and (4) the subject professional sports league.
 - Mandate in-season testing only. At most, test each athlete no more than four times annually, once each calendar quarter.
 - Permit retroactively granted therapeutic use exemptions ("TUE"); authorize Canadian-licensed physicians to prescribe medications qualifying for a TUE.
 - Allow Canadian laboratories approved by WADA to analyze samples.
 - Address the testing of players in foreign countries, or recognize as a compelling justification the absence of a player from the United States at the time of a requested test.
 - USADA model penalties are unduly harsh when applied in the context of professional hockey players in the National Hockey League.
 - Prior to public disclosure of a positive test, determine if a TUE applies and exhaust any appeal process.
 - Assess any penalty against the parties administering the collective bargaining relationship.
 - Include an obligation to provide proper education and training.

STATEMENT OF NHL COMMISSIONER GARY BETTMAN
REGARDING NHL/NHLPA PERFORMANCE ENHANCING
SUBSTANCES PROGRAM AND S. 1114 AND S. 1334

On behalf of the National Hockey League, and in response to the request of the Senate Committee on Commerce, Science and Transportation (hereinafter the “Senate Committee”), this shall constitute my written statement regarding the NHL/National Hockey League Players’ Association Performance Enhancing Substances Program and S. 1114 and S. 1334. At the outset, I would like to express the NHL’s appreciation for being afforded the opportunity to provide the Senate Committee with our comments regarding the proposed legislation. The NHL undertakes to cooperate in any way it can in the effort to eliminate the use of performance enhancing drugs in professional and amateur athletics.

NHL/NHLPA Agreement Regarding Future Testing

For Performance Enhancing Drugs

It is our conviction that, as a general matter, performance enhancing drugs are not a pervasive problem in the NHL. Nevertheless, we believe that fans in particular, and the public at large, are entitled – and deserve – to have confidence that our games are being played in a steroid-free environment. Accordingly, the NHL and its Players’ Association have recognized the need for a modernized drug testing and performance enhancing substances control policy that is specifically directed to the prevention of the use of performance enhancing drugs in our sport and, in conjunction with the recently concluded Collective Bargaining Agreement between the NHL and the NHLPA, have

established a jointly-administered Performance Enhancing Substances Program (the “Program”).

The primary purposes of the Program include:

- the education of Players regarding the health risks posed by the use of prohibited performance enhancing substances (“Prohibited Substances”);
- the treatment of Players who have used Prohibited Substances; and
- the deterrence and prevention of such use through education, random no-notice testing and the imposition of disciplinary penalties where appropriate.

(Attachment I – 2005 CBA, Section 47.1) The CBA provides that the Program shall be jointly administered by a Program Committee comprised of representatives of the League and the NHLPA, and consulting expert doctors.¹ The responsibilities of the Program Committee include:

- (a) to establish a comprehensive educational program for Players on the dangers of Prohibited Substances and the nature of the Program;
- (b) to select, and contract with, an appropriate sample collecting authority;
- (c) to select, and contract with, an appropriate testing laboratory;
- (d) to review the WADA list of prohibited performance enhancing substances and make recommendations to the NHL and NHLPA as to which performance enhancing

¹ The League and the NHLPA have retained Dr. Dave Lewis of Visions Residential Treatment Program, California, and Dr. Brian Shaw of Toronto Hospital and the Hospital for Sick Children, to serve on the Committee as consulting expert doctors. Drs. Lewis and Shaw have extensive experience in treating problems related to substance abuse, including among professional athletes, and have served as the NHL/NHLPA Substance Abuse and Behavioral Health (“Substance Abuse Program” or “SABH”) Program Doctors since the inception of the SABH Program in 1995.

substances on the WADA list are relevant to the sport of hockey and should be deemed Prohibited Substances under the Program;

- (e) to develop Player and Club notification procedures for positive test results;
- (f) to oversee the administration of Player evaluation and treatment following positive test results; and
- (g) to establish standards for the administration of "reasonable cause" testing.

(Attachment I – 2005 CBA, Section 47.2)

Based on the recommendations of the Program Committee, the NHL and the NHLPA have agreed that NHL players will be subject to testing under the terms of the Performance Enhancing Substances Program for the performance enhancing drugs designated on the WADA out-of-competition list. It is our view that this list reflects those drugs that could theoretically affect the integrity of our competition, our paramount concern. A copy of the list of banned performance enhancing substances is attached hereto. (Attachment II – Prohibited List) The Program provides for up to two (2) no-notice tests during the period from the start of Training Camp through the end of the Regular Season.² Positive tests for performance enhancing substances will result in mandatory discipline as follows:

- (1) for the first positive test, a suspension of twenty (20) NHL Games without pay, and mandatory referral to the SABH for evaluation and possible treatment;

² Given the relatively short timeframe between the ratification of the new CBA and the start of the 2005/2006 NHL season, the NHL and the NHLPA have agreed that, with respect to the 2005/2006 season only, players will be subject to testing beginning on January 15, 2006, after the consulting expert doctors have provided all Players with an orientation session regarding the Program.

- (2) for the second positive test, a suspension of sixty (60) NHL Games without pay, and mandatory referral to the SABH program for evaluation and possible treatment;
- (3) for the third positive test, a "permanent" suspension without pay, although a Player so suspended may reapply for discretionary reinstatement after a minimum period of two (2) years by making an application to the Committee.

(Attachment I – 2005 CBA, Section 47.7) The Program also provides an opportunity for a Player to challenge the imposition of any discipline in the event he is able to establish an applicable therapeutic use exemption, a testing error, mistaken use, or the use of a tainted supplement or other product (i.e., where the Player could not have reasonably ascertained the presence of the Prohibited Substance). (Attachment I – 2005 CBA, Section 47.8)

The Program incorporates a mandatory educational component which provides that the Players shall receive:

education on Prohibited Substances and the nature of the Program each League Year during Training Camp, provided, however, that no testing shall take place and no discipline shall be imposed under the Program until the Committee has provided a Player with an orientation session regarding the Program, which shall include an in-person presentation on the Program and the distribution of informational materials describing all relevant aspects of the Program, including the list of Prohibited Substances, testing procedures and disciplinary penalties.

Education and training on the details of the Program will also be provided to Club Athletic Trainers and Club physicians. Over time, and to the extent feasible, the Committee will endeavor to develop an "approved list" of nutritional

supplements, which will have been tested and certified as being free of Prohibited Substances.

(Attachment I – 2005 CBA, Section 47.4) This provision reflects the comprehensive nature of the Program, and the belief of the NHL and the NHLPA that education regarding the dangers of illegal substances (both performance enhancing and otherwise) is, perhaps, the most effective tool in preventing use and abuse.

NHL/NHLPA Substance Abuse and Behavioral Health Program

Prior to the creation and implementation of the Program, the NHL and the NHLPA addressed problems of substance abuse (including abuse of performance enhancing substances) through the NHL/NHLPA Substance Abuse Program (Attachment III), which was jointly developed and implemented in 1995 in conjunction with the parties' prior collective bargaining agreement. The Substance Abuse Program was designed to be a "comprehensive effort to address substance abuse among NHL players and their families, to treat those with a substance abuse problem in a confidential, fair and effective way, and to deter such abuse in the future." (Attachment III, SABH Program Section 1) In order to accomplish these goals, the Substance Abuse Program incorporates education, counseling, inpatient and outpatient treatment, follow-up care, and where appropriate, punitive sanctions, up to and including permanent suspension from play in the League. On a going-forward basis, those players who are found to be using performance enhancing substances will be subject to mandatory discipline as outlined above under the Performance Enhancing Substances Program, and will also be referred to the Substance Abuse Program for evaluation and treatment.

Historically, the players who have been treated under the Substance Abuse Program have exhibited problems associated with alcohol and/or “recreational” drug use, rather than steroid (or steroid precursor) use. The experience of our Substance Abuse Program in this regard is not surprising when one considers that primary of the alleged benefits of steroid use – significant large muscle development – is not consistent with playing hockey at the highest levels of the sport, and the resulting bulkiness attributable to steroid use simply is not a desired characteristic of skilled NHL players.³ Nevertheless, in the event NHL players were to exhibit symptoms associated with abuse of performance enhancing drugs, the Substance Abuse Program was broad enough in scope to provide treatment (and if appropriate, discipline) for such players and the Substance Abuse Program Doctors were empowered to intervene in any manner they felt was appropriate.

Drug Testing of NHL Players in International Hockey Competitions

The frequent and consistent participation of NHL players in international competitions, and the drug testing NHL players undergo in connection therewith, provide objective support for our belief that the use of performance enhancing drugs by NHL players is negligible, to the extent it exists at all.⁴ Over the past ten years, NHL players have represented their nations of origin annually in connection with the IIHF World

³ Our belief that steroid use is not desired by or prevalent among skilled hockey players is seemingly confirmed by the fact that there have been only eight positive results in approximately 3,100 tests of NHL and non-NHL players administered at the World Hockey Championships (conducted by the International Ice Hockey Federation (“IIHF”)) since 1993/94.

⁴ We are aware of recent statements by Dave Morissette and Andrew Peters regarding their use of performance enhancing drugs, but for the reasons set forth above, do not believe that their experiences are representative of the vast majority of NHL players. Indeed, Dave Morissette played in only 11 NHL games in his career. We further note that Mr. Peters’ assertion that he stopped taking andro after the U.S. Department of Health and Human Services issued a report about the health risks associated with taking the substance provides further support for our assertion that it is essential to provide training and education on the dangers of performance enhancing drugs.

Championships, twice in Olympic competitions in 1998 and 2002, and just this past year in the 2004 World Cup of Hockey, which the NHL and the NHLPA organized and sponsored. In connection with international play, the NHL and its players are held to and abide by the international standards of the World Anti-Doping Agency (“WADA”), which have been adopted by the IIHF.

In the past ten years, of the nearly 1,000 NHL players who have participated in the IIHF World Championships, the Olympics, and World Cup of Hockey competitions, and were subject to drug testing in connection therewith, we are aware of only three positive tests for performance enhancing drugs.⁵ And of the three, one of the players tested positive for salbutamol, a drug that is also used for asthma as a Proventil inhaler, and which may be used with a Therapeutic Use Exemption. A second player tested positive for tramadol, a substance which is designated as an “allowed narcotic” (i.e., a prescribed painkiller). The third player established a “mistaken use” defense in connection with his use of over-the-counter nutritional supplements.

S. 1114, The Clean Sports Act of 2005

The National Hockey League has reviewed the proposed Clean Sports Act of 2005 and, as stated above, is supportive of a program featuring mandatory testing and discipline imposed in connection with an athlete’s use of performance enhancing drugs. The NHL remains of the belief that, given the mandatory and effective Program agreed to by the NHL and the NHLPA, which has been designed to eradicate the use of all

⁵ In connection with international competitions in which NHL players have participated over the past ten years, the Program Doctors along with the USOC administered the pre-competition drug testing for the Olympics, and the IOC administered the in-competition testing. The Program Doctors administered the out-of-competition and in-competition testing for the World Cup of Hockey. The IIHF administered the in-competition testing for the World Championships. With respect to the tests administered by the IIHF, the IOC and the USOC, it is our understanding that no NHL player had a positive test result for performance enhancing drugs; however, we do not have access to specific data or testing results.

performance enhancing drugs from our game, we do not see a need for the proposed legislation as it would relate to the NHL. However, should Congress decide to proceed in this area and legislate along the lines that this proposed legislation contemplates, the NHL's specific comments regarding the provisions of the proposed legislation are as follows:

- The proposed legislation provides that professional sports leagues shall be subject to the minimum doping control standards established by the United States Anti-Doping Agency Protocol ("USADA") for Olympic Movement Testing, and shall consult with USADA in the development of its test distribution plan, its drug testing protocols, and its adjudication process. We believe that the Director of the Office of National Drug Control Policy shall be responsible for establishing minimum doping control standards for each sport, as well as test distribution plans, testing protocols and adjudication procedures, and that the Director shall establish the foregoing after consultation with: (1) the National Institute on Drug Abuse ("NIDA"), which has particular expertise in addressing substance abuse; (2) the United States Department of Transportation, which is one of the largest workplace testing entities in the world; (3) USADA, which has expertise in the non-workplace testing arena of amateur competitions; and (4) the subject professional sports league. We believe that the foregoing entities together would provide the Director with the information, resources, and practical experience necessary to develop an appropriate workplace testing policy and procedure applicable to the employees (i.e., the players) for each professional sport. We do not believe it is appropriate for the standards set by USADA to set a floor for the minimum requirements applicable for the professional sports leagues, by default. (See Section 4(b)) We believe

that the foregoing process shall also apply in the context of the annual certifications outlined in Sections 4(b)(2) and 4(b)(3).

- Section 4(b)(1)(A) of the proposed legislation provides for “each professional athlete [to be] tested a minimum of 5 times each calendar year that such athlete is competing in games organized by the major professional league.” Section 4(b)(1)(B) provides that each athlete shall be tested “(i) at least 3 times, each with no advance notice, during each season of play; and (ii) at least 2 times, each with no advance notice, during the off-season.” The National Hockey League plays its games in two different countries and features athletes hailing from twenty-two countries around the globe. One-third of NHL players are from outside of North America and eighty-five percent are from outside the United States. For this reason, and giving appropriate consideration to the fact that the NHL does not have a pervasive problem with its players using performance enhancing substances, in-season testing makes particular sense. While we do not object to subjecting NHL players to random no-notice testing during the off-season, we would not advocate that it be mandatory for sports leagues in general, and the NHL in particular, to conduct off-season testing given the logistical difficulties that would arise in connection with testing players scattered throughout the world. The standard adopted by the NHL and the NHLPA, requiring up to two (2) in-season tests, was designed to insure the effectiveness of the Program while recognizing the realities of professional hockey. In the event legislation is passed requiring more than two tests per calendar year, we would advocate that there be no more than four tests required annually, and that it be permissible to evenly distribute such tests once per calendar quarter.

- Section 4(b)(4) provides that “a major professional league may make exceptions for any prohibited substances that have been properly prescribed by a doctor of medicine licensed in the United States for legitimate and documented therapeutic purposes.” We would recommend that this provision be clarified to provide that the exception may be granted retroactively by a medical review officer, after a player has tested positive for a banned substance in the event an investigation reveals that the substance was properly prescribed for a legitimate and documented therapeutic purpose. In addition, the fact that there are six (6) Canadian-based NHL teams would necessitate that Canadian licensed physicians also be authorized to prescribe medications qualifying for a therapeutic use exemption.⁶

- Section 4(b)(5) provides for the samples to be analyzed by a laboratory approved by USADA. We would recommend that Canadian-based laboratories approved by the World Anti-Doping Agency (“WADA”) also be authorized to analyze the samples.

- Section 4(b)(6) provides that a “refusal by a professional athlete to submit to a test or a failure of a professional athlete to submit to a test without compelling justification shall also be considered a positive test.” If the requirement regarding mandatory off-season testing is maintained, we would recommend that the legislation address the testing of players in foreign countries (of course, any such testing, if allowed at all, would need to be performed in accordance with applicable laws in the local jurisdiction), or alternatively, recognize as a compelling justification the absence of a player from the United States at the time of a requested test, thus recognizing the international makeup of

⁶ Canadian NHL team physicians also may treat and prescribe medications to visiting teams’ players -- including United States-based teams -- who suffer an injury while playing in one of the 246 NHL games played in Canada.

NHL players and the fact that many such players return to their native countries during the off-season.

- Section 4(b)(7) of the proposed legislation provides for a minimum suspension of two (2) years for an athlete who tests positive for their first violation, and for the “lifetime ban of the professional athlete from all major professional leagues” for an athlete who commits a second violation. The NHL agrees that a player who tests positive for performance enhancing drugs should be subject to a significant punishment, and further agrees that progressive discipline should be imposed for a player who tests positive more than once. We believe that the USADA model penalties are unduly harsh when applied in the context of professional hockey players in the National Hockey League. The proposed legislation incorporates a significant and meaningful penalty of a two-year ban for a first-time offender in the context of international “amateur” competitions that take place relatively infrequently, as compared to NHL games. In the international sports environment, events are generally conducted on an annual, bi-annual or quadrennial basis (e.g., Olympics, World Championships), while in the NHL, there are 82 regular season games each season in addition to playoff games for eligible clubs. Imposition of identical penalties in these two distinct environments would result in a disparate, and in our opinion, unduly harsh impact on NHL players. Further, given the limited career length of a professional athlete, we believe a two (2) year suspension for a first-time offender is too harsh, resulting in an excessive impact on the athlete’s ability to earn a “livelihood.”

- Section 4(b)(9) of the proposed legislation provides that a positive test shall result in the public disclosure of the “identity of any professional player who has tested positive

as well as the prohibited substance or prohibited method for which he tested positive not later than 30 days after receiving the test results.” The NHL agrees that it would be appropriate to publicly disclose the name of an athlete who has tested positive for the use of a performance enhancing drug, but believe that prior to such disclosure -- and even in the event an appeal is not filed -- it would be prudent to implement a process that would require a medical review officer to contact the player who tested positive to determine whether there is an legitimate medical explanation⁷ for the player’s use of the banned substance. If so, and the player has a proper medical prescription authorizing the use of the substance, the positive test results should be considered cancelled, penalties should not be imposed, and no public disclosure of the test result should be made. If, however, a legitimate medical explanation for the player’s use of the banned substance does not exist, it would then be appropriate to make the positive test results public and impose discipline, in addition to providing counseling and treatment.

- Section 6 of the proposed legislation provides that the Commission may seek a civil penalty of not more than \$1,000,000 for each violation of section 4. We would advocate that any such penalty be assessed to the parties administering the collective bargaining relationship.

- In the event legislation is passed regarding performance enhancing substances, we would recommend that such legislation include an obligation on the professional sports leagues to provide in-person education and training to its players on an annual basis regarding prohibited substances and the nature of the applicable testing program, including the penalties associated with violations of the program.

⁷ See 49 C.F.R. §40.137 (2003) (Department of Transportation Procedures for Transportation Workplace Drug Testing Programs).

S. 1334, Professional Sports Integrity and Accountability Act

To the extent S. 1334 has provisions identical to S. 1114, the NHL’s comments regarding the proposed legislation are set forth above. The NHL’s specific comments regarding the provisions of S. 1334 that are materially different from S. 1114 are as follows:

- Section 5(d)(1) of the proposed legislation provides for “each professional athlete [to be] tested for the use of prohibited substances and methods no less than 3 times in each calendar year that the athlete competes in a professional sports league.” Section 5(d) further provides for tests to be conducted “at random intervals throughout the entire calendar year . . .” As stated above, in-season testing makes particular sense for the NHL. The proposed legislation seems to permit such testing to occur at random intervals in each “third” of the calendar year, thus effectively addressing the impracticalities associated with off-season testing of non-North American based NHL players. We would recommend that each team’s entire roster of players be tested at the same time during the NHL season on a no-notice basis.

- Section 5(e) of the proposed legislation provides that a professional sports league shall publicly disclose the name of any violator, the penalty imposed, and a description of the violation “not later than 10 days after receiving notice of a violation . . .” As stated above, it is our view that public disclosure would not be appropriate until after a medical review officer has contacted the player who tested positive to determine whether there is a legitimate medical explanation for the player’s use of the banned substance, and any appeal process has been fully adjudicated.

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The public is entitled to have confidence in the integrity of competition in the game of hockey and in all professional sports, and to watch the exceptional athletes of today compete on a level playing field, free of the influence of performance enhancing drugs. Every professional athlete serves as a role model, and with that comes a corresponding responsibility to engage exclusively in conduct that will bring honor to himself, his team, and the game in which he earns his livelihood. For these reasons, we support the requirement that the NHL and the other professional sports leagues conduct mandatory testing on athletes for performance enhancing drugs.

ARTICLE 47
PERFORMANCE ENHANCING SUBSTANCES PROGRAM

47.1 Introduction. The parties agree to the establishment of a jointly-administered Performance Enhancing Substances Program ("Program"), which shall have as its primary purposes the education of Players regarding the health risks posed by the use of prohibited performance enhancing substances ("Prohibited Substances"); the treatment of Players who have used Prohibited Substances; and the deterrence and prevention of such use through education, random no-notice testing and the imposition of disciplinary penalties where appropriate.

47.2 Program Committee. The Program shall be jointly administered by a Program Committee ("Committee") comprised of an equal number of League and NHLPA representatives and one (1) consulting expert doctor nominated by each party. The responsibilities of the Committee shall include, among other things:

- (a) to establish a comprehensive educational program for Players on the dangers of Prohibited Substances and the nature of the Program;
- (b) to select, and contract with, an appropriate sample collecting authority;
- (c) to select, and contract with, an appropriate testing laboratory;
- (d) to review the WADA list of prohibited performance enhancing substances and make recommendations to the NHL and NHLPA as to which performance enhancing substances on the WADA list are relevant to the sport of hockey and should be deemed Prohibited Substances under the Program;
- (e) to develop Player and Club notification procedures for positive test results;
- (f) to oversee the administration of Player evaluation and treatment following positive test results; and
- (g) to establish standards for the administration of "reasonable cause" testing.

The Committee shall endeavor to render unanimous decisions with respect to matters committed to it pursuant to this Article. In the absence of a unanimous decision, a decision by the majority of Committee members shall govern. When a majority decision cannot be reached, the two (2) consulting expert doctors shall select an ad hoc expert doctor who shall cast the deciding vote with respect to the matter at issue.

47.3 Scope of Program. The Program shall be limited to addressing the testing for and use of prohibited performance enhancing substances (Prohibited Substances). All other forms of "substance abuse" and behavioral and domestic issues requiring employee assistance will continue to be handled through the NHL/NHLPA Program for Substance Abuse and Behavioral Health (the "SABH Program").

47.4 Educational Initiatives. Players shall receive education on Prohibited Substances and the nature of the Program each League Year during Training Camp, provided, however, that no testing shall take place and no discipline shall be imposed under the Program until the Committee has provided a Player with an orientation session regarding the Program, which shall include an in-person presentation on the Program and the distribution of informational materials describing all relevant aspects of the Program, including the list of Prohibited Substances, testing procedures and disciplinary penalties. Education and training on the details of the Program will also be provided to Club Athletic Trainers and Club physicians. Over time, and to the extent feasible, the Committee will endeavor to develop an "approved list" of nutritional supplements, which will have been tested and certified as being free of Prohibited Substances.

47.5 Prohibited Substances. The NHL and the NHLPA shall be responsible for maintaining the list of Prohibited Substances (the "Prohibited Substances List"). Upon receiving the Committee's recommendations made pursuant to Section 47.2(d) above, the parties shall confer and agree upon the Prohibited Substances to be included on the List. Changes to substances on the List may only be as negotiated by the NHL and the NHLPA. There shall be no retesting of samples based on newly discovered substances not included on the Prohibited Substances List at the time of the original testing.

47.6 Testing Procedures. Every NHL Player who has participated in an orientation session pursuant to Section 47.4 will be subject to up to two (2) no-notice tests during the period from the start of Training Camp through the end of the Regular Season. All such tests will be conducted at the Clubs' facility on the day of a scheduled practice, as opposed to on a game day.

47.7 Disciplinary Penalties. Positive tests for performance enhancing substances will result in mandatory discipline as follows:

(a) for the first positive test, a suspension of twenty (20) NHL Games without pay, and mandatory referral to the SABH program for evaluation and possible treatment;

(b) for the second positive test, a suspension of sixty (60) NHL Games without pay, and mandatory referral to the SABH program for evaluation and possible treatment;

(c) for the third positive test, a "permanent" suspension without pay, although a Player so suspended can reapply for discretionary reinstatement after a minimum period of two (2) years by making an application to the Committee.

47.8 Appeal Procedures. The NHLPA may, on a Player's behalf, appeal a positive test to the Impartial Arbitrator on an expedited basis, utilizing the procedures set forth in Article 17 of the Agreement. A strict liability standard will be employed with respect to all positive tests. Notwithstanding the above, the Player shall be entitled to challenge the imposition of any discipline in the event he is able to establish an applicable therapeutic use exemption (as described in Section 47.9 hereof), a testing error, mistaken use, or the use of a tainted supplement or other product (i.e., where the Player could not have

reasonably ascertained the presence of the Prohibited Substance). To the extent a Player successfully establishes a defense to a positive test, he may avoid the mandatory suspension, but will in all cases be referred to the SABH Program for evaluation and possible treatment. A Player who files a timely appeal may not be suspended pursuant to Section 47.7 until a decision on the appeal has been rendered by the Impartial Arbitrator.

47.9 Therapeutic Use Exemption. A Player may apply to the Committee for a therapeutic use exemption with respect to a particular Prohibited Substance. The Committee shall consider and act upon such Player's application expeditiously and approval of the application shall not be unreasonably withheld.

47.10 Confidentiality. Test results will be kept confidential, subject to the following limited exception: once a positive test has been confirmed after appeal to the Impartial Arbitrator, or if no appeal is taken, the Player suspended will be identified, and it will be announced that the Player "has been suspended for violating the terms of the NHL/NHLPA Program for Performance Enhancing Substances."

47.11 Program Funding. Any salary forfeited by a Player by reason of a suspension imposed pursuant to Section 47.7 will be utilized to help defer the costs of both the Program and the SABH Program. All costs of administering the Program, including the costs associated with mandatory no-notice testing, shall be the responsibility of the NHL.

47.12 Mandatory Legislation. The parties agree that to the extent mandatory and binding legislation goes into effect that requires material changes to the Program, the provisions of the Program will become null and void and the parties will endeavor to collectively bargain over a revised Program that complies with such legislation and that is agreeable to both parties.

THE 2005 PROHIBITED LIST WORLD ANTI-DOPING CODE

Valid 1 January 2005

The use of any drug should be limited to medically justified indications

PROHIBITED SUBSTANCES

S1. ANABOLIC AGENTS

Anabolic agents are prohibited.

1. Anabolic Androgenic Steroids (AAS)

a. Exogenous* AAS, including:

18 α -homo-17 β -hydroxyestr-4-en-3-one; bolasterone; boldenone; boldione; calusterone; clostebol; danazol; dehydrochloromethyltestosterone; delta1-androstene-3,17-dione; delta1-androstenediol; delta1-dihydro-testosterone; drostanolone; ethylestrenol; fluoxymesterone; formebolone; furazabol; gestrinone; 4-hydroxytestosterone; 4-hydroxy-19-nortestosterone; mestanolone; mesterolone; metenolone; methandienone; methandriol; methyldienolone; methyltrienolone; methyltestosterone; mibolerone; nandrolone; 19-norandrostenediol; 19-norandrostenedione; norbolethone; norclostebol; norethandrolone; oxabolone; oxandrolone; oxymesterone; oxymetholone; quinbolone; stanozolol; stenbolone; tetrahydrogestrinone; trenbolone and other substances with a similar chemical structure or similar biological effect(s).

b. Endogenous** AAS:

androstenediol (androst-5-ene-3 β ,17 β -diol); androstenedione (androst-4-ene-3,17-dione); dehydroepiandrosterone (DHEA); dihydrotestosterone; testosterone.

and the following metabolites and isomers:

5 α -androstane-3 α ,17 α -diol; 5 α -androstane-3 α ,17 β -diol; 5 α -androstane-3 β ,17 α -diol; 5 α -androstane-3 β ,17 β -diol; androst-4-ene-3 α ,17 α -diol; androst-4-ene-3 α ,17 β -diol; androst-4-ene-3 β ,17 α -diol; androst-5-ene-3 α ,17 α -diol; androst-5-ene-3 α ,17 β -diol; androst-5-ene-3 β ,17 α -diol; 4-androstenediol (androst-4-ene-3 β ,17 β -diol); 5-androstenedione (androst-5-ene-3,17-dione); epi-dihydrotestosterone; 3 α -hydroxy-5 α -androstan-17-one; 3 β -hydroxy-5 α -androstan-17-one; 19-norandrosterone; 19-noretiocholanolone.

Where a *Prohibited Substance* (as listed above) is capable of being produced by the body naturally, a *Sample* will be deemed to contain such *Prohibited Substance* where the concentration of the *Prohibited Substance* or its metabolites or markers and/or any other relevant ratio(s) in the *Athlete's Sample* so deviates from the range of values normally found in humans that it is unlikely to be consistent with normal endogenous production. A *Sample* shall not be deemed to contain a *Prohibited Substance* in any such case where the *Athlete* proves by evidence that the concentration of the *Prohibited Substance* or its metabolites or markers and/or the relevant ratio(s) in the *Athlete's Sample* is attributable to a physiological or pathological condition. In all cases, and at any concentration, the laboratory will report an *Adverse Analytical Finding* if, based on any reliable analytical method, it can show that the *Prohibited Substance* is of exogenous origin.

If the laboratory result is not conclusive and no concentration as referred to in the above paragraph is found, the relevant *Anti-Doping Organization* shall conduct a further investigation if there are serious indications, such as a comparison to reference steroid profiles, for a possible *Use of a Prohibited Substance*.

If the laboratory has reported the presence of a T/E ratio greater than four (4) to one (1) in the urine, further investigation is obligatory in order to determine whether the ratio is due to a physiological or pathological condition, except if the laboratory reports an *Adverse Analytical Finding* based on any reliable analytical method, showing that the *Prohibited Substance* is of exogenous origin.

In case of an investigation, it will include a review of any previous and/or subsequent tests. If previous tests are not available, the *Athlete* shall be tested unannounced at least three times within a three month period.

Should an *Athlete* fail to cooperate in the investigations, the *Athlete's Sample* shall be deemed to contain a *Prohibited Substance*.

2. Other Anabolic Agents, including but not limited to:

Clenbuterol, zeranol, zilpaterol.

For purposes of this section:

* "exogenous" refers to a substance which is not capable of being produced by the body naturally.

** "endogenous" refers to a substance which is capable of being produced by the body naturally.

S2. HORMONES AND RELATED SUBSTANCES

The following substances, including other substances with a similar chemical structure or similar biological effect(s), and their releasing factors, are prohibited:

- 1. Erythropoietin (EPO);**
- 2. Growth Hormone (hGH), Insulin-like Growth Factor (IGF-1), Mechano Growth Factors (MGFs);**
- 3. Gonadotrophins (LH, hCG);**
- 4. Insulin;**
- 5. Corticotrophins.**

Unless the *Athlete* can demonstrate that the concentration was due to a physiological or pathological condition, a *Sample* will be deemed to contain a *Prohibited Substance* (as listed above) where the concentration of the *Prohibited Substance* or its metabolites and/or relevant ratios or markers in the *Athlete's Sample* so exceeds the range of values normally found in humans so that it is unlikely to be consistent with normal endogenous production.

The presence of other substances with a similar chemical structure or similar biological effect(s), diagnostic marker(s) or releasing factors of a hormone listed above or of any other finding which indicate(s) that the substance detected is of exogenous origin, will be reported as an *Adverse Analytical Finding*.

S3. BETA-2 AGONISTS

All beta-2 agonists including their D- and L-isomers are prohibited. Their use requires a Therapeutic Use Exemption.

As an exception, formoterol, salbutamol, salmeterol and terbutaline, when administered by inhalation to prevent and/or treat asthma and exercise-induced asthma/broncho-constriction require an abbreviated Therapeutic Use Exemption.

Despite the granting of a Therapeutic Use Exemption, when the Laboratory has reported a concentration of salbutamol (free plus glucuronide) greater than 1000 ng/mL, this will be considered as an *Adverse Analytical Finding* unless the athlete proves that the abnormal result was the consequence of the therapeutic use of inhaled salbutamol.

S4. AGENTS WITH ANTI-ESTROGENIC ACTIVITY

The following classes of anti-estrogenic substances are prohibited:

- 1. Aromatase inhibitors including, but not limited to, anastrozole, letrozole, aminoglutethimide, exemestane, formestane, testolactone.**
- 2. Selective Estrogen Receptor Modulators (SERMs) including, but not limited to, raloxifene, tamoxifen, toremifene.**
- 3. Other anti-estrogenic substances including, but not limited to, clomiphene, cyclofenil, fulvestrant.**

S5. DIURETICS AND OTHER MASKING AGENTS

Diuretics and other masking agents are prohibited.

Masking agents include but are not limited to:

Diuretics*, epitestosterone, probenecid, alpha-reductase inhibitors (e.g. finasteride, dutasteride), plasma expanders (e.g. albumin, dextran, hydroxyethyl starch).

Diuretics include:

acetazolamide, amiloride, bumetanide, canrenone, chlortalidone, etacrynic acid, furosemide, indapamide, metolazone, spironolactone, thiazides (e.g. bendroflumethiazide, chlorothiazide, hydrochlorothiazide), triamterene, and other substances with a similar chemical structure or similar biological effect(s).

* A Therapeutic Use Exemption is not valid if an *Athlete's* urine contains a diuretic in association with threshold or sub-threshold levels of a *Prohibited Substance(s)*.

PROHIBITED METHODS

M1. ENHANCEMENT OF OXYGEN TRANSFER

The following are prohibited:

- a. Blood doping, including the use of autologous, homologous or heterologous blood or red blood cell products of any origin, other than for medical treatment.
- b. Artificially enhancing the uptake, transport or delivery of oxygen, including but not limited to perfluorochemicals, efaproxiral (RSR13) and modified haemoglobin products (e.g. haemoglobin-based blood substitutes, microencapsulated haemoglobin products).

M2. CHEMICAL AND PHYSICAL MANIPULATION

The following is prohibited:

Tampering, or attempting to tamper, in order to alter the integrity and validity of *Samples* collected in *Doping Controls*.

These include but are not limited to intravenous infusions*, catheterisation, and urine substitution.

* Except as a legitimate acute medical treatment, intravenous infusions are prohibited.

M3. GENE DOPING

The non-therapeutic use of cells, genes, genetic elements, or of the modulation of gene expression, having the capacity to enhance athletic performance, is prohibited.

Attachment III



**NHL/NHLPA SUBSTANCE ABUSE AND
BEHAVIORAL HEALTH PROGRAM**

CONFIDENTIAL

**PLEASE DO NOT RELEASE UNLESS WRITTEN PERMISSION
HAS BEEN RECEIVED FROM EITHER THE NHL OR THE
NHLPA OFFICES**

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM

1. Overview and Statement of Purpose

The Joint NHL/NHLPA substance abuse and behavioral health program is a comprehensive effort to address substance abuse among NHL players and their families, to treat those with a substance abuse problem in a confidential, fair and effective way, and to deter such abuse in the future. The program seeks to accomplish these goals through a coordinated program of education, counseling, inpatient and outpatient treatment, follow-up care, and, where appropriate, sanctions. It has the full support of the League and the Players' Association and will be incorporated into the Collective Bargaining Agreement.

2. Professional Component

A. Doctors

The program will be administered by qualified doctors selected by the League and the NHLPA (the "program doctors"). These doctors shall be knowledgeable in each of the key elements of the program, including education, counseling, treatment and follow-up care. The doctors shall administer the program and shall be responsible for all professional judgments, including but not limited to:

- Development of an educational program on substance abuse to be presented at least once each year to NHL players. There will also be a training program on HIV education presented to NHL players once per year.
- Establishment of a comprehensive multi-national counseling network to include a 24-hour toll-free number and a network of designated counseling professionals in each NHL city.
- Development of a standardized medical and psychological assessment to be used to evaluate players with substance abuse problems.
- Making decisions concerning treatment and follow-up care, and ensuring compliance with those treatment programs. All substance abuse and behavioral health treatments of players in the program will be determined by the program doctors.
- Selection and evaluation of laboratory, treatment and follow-up care facilities.
- Regular consultations with NHL and NHLPA executives as appropriate.
- Appropriate maintenance of confidentiality of player records.

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The parties have designated Dr. David Lewis and Dr. Brian Shaw to serve as the program doctors, Dr. Lewis having been appointed by the NHL and Dr. Shaw by the NHLPA. Either party may dismiss the doctor that it appointed and appoint a successor at any time. In the event that the NHLPA wishes to dismiss Dr. Lewis, it may do so only if it simultaneously dismisses Dr. Shaw. Similarly, the League may dismiss Dr. Shaw, but only if it simultaneously dismisses Dr. Lewis. Any such personnel changes will require thirty days written notice to the other party and the affected doctor(s).

B. Treatment Facilities

Drs. Shaw and Lewis will recommend facilities for inpatient treatment based on their assessment of the needs of each individual case. The use of a treatment facility operated by either of the program doctors is permissible provided both program doctors agree. Treatment facilities will be selected based on factors determined by the doctors, but all such facilities will be capable of providing high quality individualized care, providing a broad spectrum of care, and of addressing the full range of issues that accompany substance abuse.

C. Laboratories

The doctors will select laboratories in both the United States and Canada to perform needed drug testing services in support of the program. Such laboratories will be certified by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), the College of American Pathologists, or their Canadian equivalents. As appropriate, the doctors are authorized independently to review lab performance, including the use of blind quality control reviews. The doctors are also authorized to retain support services related to the collection of specimens for testing or the assessment of laboratory quality. All specimen collection will be done in accordance with recognized chain-of-custody procedures of the type specified in the SAMHSA guidelines. A sample testing protocol is attached as Exhibit A.

3. Education and Treatment**A. Education Program**

The program doctors will meet with the players on each team at least once each year to review issues relating to substance abuse. The doctors will be responsible for developing the content of the education program and the teaching materials used (e.g., lecture, videotape, printed materials, interactive computer programs, etc.) The education program will include instruction on the risks of alcohol and drug use, how a player can help teammates who may have a substance abuse problem, how to deal with high risk situations involving alcohol and drugs, and how a player and his family can obtain assistance under this program.

NHL/NHLPA SABH PROGRAM Page 3

In addition, copies of this program will be distributed to each NHL player and will be available at the Clubs' offices for review by the players on request. The educational program will be modified from time to time to incorporate player feedback and additional research advances. At the request of the NHL (or one of its Member Clubs) or the NHLPA, the program doctors will meet to review the education program and respond to any related questions.

B. Counseling Program

The program doctors will establish an employee assistance-type program, which will be available for all players and their families. A toll-free number will be established for the use of NHL players. That number will be in operation 24 hours a day throughout the year. All contacts through this employee assistance program will be strictly confidential unless the player (or the player's family member) is to be treated in which case, the only disclosure will be that required by the necessary insurance payment protocols or in the case of players, if disciplined under the terms of this program. The program will be available to any player or his family member and will offer access to trained counselors for a wide range of problems, including substance abuse, related financial issues, domestic abuse, family relationships, stress management, etc. Issues relating to substance abuse will be handled within this program through personal contact between the caller and one of the program doctors or his designee, while other problems may be referred to appropriate specialist agencies or local resources.

C. Substance Abuse Evaluation

Any player who enters the program will first receive a comprehensive medical and psychological evaluation, which shall be administered by one of the program doctors or their designee. A sample evaluation profile is attached as Exhibit B.

D. Treatment

Following the substance abuse evaluation, the program doctors will determine what, if any, treatment is required for the player. Treatment may include any or all of the following: counseling, outpatient treatment, inpatient treatment in a designated facility. The program doctors will determine the type and length of treatment that is appropriate; in the event that inpatient treatment is indicated, the program doctors will designate the facility in which the player will be treated, the initial length of stay, and, in conjunction with the treatment providers at the designated facility, the course of treatment that the player will undergo. Where they determine it appropriate, the program doctors may extend the period of inpatient treatment. Recommendations regarding treatment made by the program doctors are binding on the player involved. The program doctors are authorized to share their findings and observations, including any written records, with designated treatment providers and facilities, and to obtain health/medical records and other documents from those providers and facilities.

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As part of the treatment, the program doctors may prescribe follow-up care arrangements, including on-going counseling, support meetings and the like, for affected players. In addition, as part of treatment and follow-up care, players may be required to undergo periodic substance testing at a frequency and on a schedule to be determined by the doctors. Such testing may take place both in season and during the off-season.

Players are expected fully to cooperate with any treatment and follow-up care prescribed by the program doctors or set forth in a follow-up plan or similar arrangement. The program doctors may assess fines and suspensions against players for failure to comply with the treatment and follow-up care program. In addition, in appropriate cases, the program doctors may advance the player one "stage" in the program, thereby subjecting him to possible disciplinary action.

The progress of all players undergoing treatment and follow-up care will be monitored by the program doctors, who will regularly report on the progress of such players to the NHL and NHLPA. A standard consent form to release information under the terms of the program will be obtained for all players in the program (see Exhibit C).

E. Role of Team Personnel

The program doctors may consult with the team doctor of a player in treatment and may involve the team doctor in the treatment and follow-up care process as appropriate. In addition, team doctors or other team personnel, including trainers, coaches, and managers, may contact the program doctors concerning a specific player. These personnel may refer players to the program doctors for evaluation. Consistent with program goals and confidentiality, the program doctors will decide on the most reasonable plan for evaluation.

4. Discipline

Players may be disciplined for substance abuse violations depending on the nature and severity of the violation. As described below, players with identified substance abuse problems will be placed in a particular stage in the program, with disciplinary consequences associated with the stages as set forth below.

A. Discipline for Alcohol Abuse Violations

If a player voluntarily seeks treatment for alcohol abuse and such treatment, as determined by the program doctors, is on an outpatient basis only (i.e., the player is not treated in an inpatient setting), the player will continue to be paid his full NHL salary and no penalty of any kind will be imposed on the player so long as he follows his prescribed treatment and follow-up care program.

A player who voluntarily seeks treatment for alcohol abuse and whose initial treatment is on an inpatient basis will be placed in stage one of the program. Such a player will continue to be

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paid his full NHL salary and will have no penalty imposed on him so long as he fully complies with his prescribed treatment and follow-up care program.

A player who in the opinion of the program doctors violates his stage one treatment or follow-up care program, will be placed in stage two of the program. Such a player will be suspended without pay during the active phase of his treatment and will be eligible for reinstatement upon the recommendation of the program doctors after consultation with the NHL and the NHLPA although reinstatement is not assured. During a player's suspension, he will receive a stipend to meet certain basic living expenses, the amount of which will be determined by the program doctors.

A player who in the opinion of the program doctors violates his stage 2 treatment and who requires a third or subsequent inpatient treatment for alcohol abuse will be placed in stage three of the program. Such a player will be suspended without pay (except for a limited stipend the amount of which will be determined by the program doctors) during his active treatment and will be eligible for reinstatement upon recommendation of the program doctors after consultation with the NHL and NHLPA, although reinstatement is not assured.

B. Discipline for Drug Abuse Violations

If a player voluntarily seeks treatment for drug abuse and is treated, as determined by the program doctors, on an outpatient basis only (i.e., the player is not treated in an inpatient setting), the player will continue to be paid his full NHL salary and no penalty of any kind will be imposed on that player so long as he follows his prescribed program of treatment and follow-up care.

A player who enters the program for a drug abuse problem that, in the opinion of the program doctors, requires inpatient treatment, will be placed in stage one of the program. Such a player will continue to be paid his full NHL salary, and no penalty will be imposed on him, so long as he fully complies with his prescribed treatment and follow-up care program.

A player who, in the opinion of the program doctors, violates his stage one treatment or follow-up care program will be placed in stage two of the program. Such a player will be suspended without pay during his active treatment and will be eligible for reinstatement upon the recommendation of the program doctors after consultation with the NHL and the NHLPA although reinstatement is not assured. During a player's suspension, he will receive a stipend to meet certain basic living expenses the amount of which will be determined by the program doctors.

A player who, in the opinion of the program doctors, violates the prescribed program of treatment or follow-up care in stage two will be placed in stage three of the program. Such player will be suspended without pay (except for a limited stipend the amount of which will be determined by the program doctors) for not less than 6 calendar months. It is understood that it is

NHL/NHLPA SABH PROGRAM Page 6

not advisable for players in stage 3 to return to play just before or during the playoffs. Such a player will be eligible for reinstatement upon the recommendation of the program doctors following consultation with the NHL and NHLPA although reinstatement is not assured..

Following a violation of stage three treatment or follow-up care a player will be placed in stage four and will be suspended from the NHL without pay (except for a limited stipend the amount of which will be determined by the program doctors) for at least one season. Any reinstatement thereafter will be at the discretion of the NHL and the NHLPA, and reinstatement is not assured.

C. Discipline Relating to Criminal Arrests or Convictions

Any player arrested for a violation of law relating to a controlled substance or substance abuse (including but not limited to driving under the influence, driving while intoxicated, or the equivalent) is required to submit to a substance abuse evaluation and to such treatment as may be deemed appropriate by the program doctors. Under these circumstances, if the program doctors determine that treatment is required, the player will be placed in stage 1 of the alcohol or drug program.

If a player is convicted of a controlled substance offense (including under a plea arrangement or similar procedure), in addition to any other League discipline to which the player may be subject outside of this agreement, he will be automatically placed at stage 2 of the drug program.

5. Funding and Administration

The program shall be administered by the program doctors, who may retain such administrative support and assistance as they reasonably require from time to time. The program doctors shall submit an annual budget to the NHL and NHLPA and must seek approval of both parties to spend in excess of 105% of the budgeted amount.

The NHL and NHLPA shall jointly fund the administrative fees of Dr. Shaw and Dr. Lewis, inclusive of all administrative costs set forth in the approved budget. The NHL medical insurance program will provide for all prescribed treatment costs of the program. The NHL medical insurance program will provide that in each inpatient treatment at a drug rehabilitation center, the insurance program will cover treatment for a period of up to 60 days or longer with the specific authorization of the program doctors. In so far as these costs are not covered by the major medical plan, they will be paid for by the player's team. Similarly, the plan will be amended to authorize payment of costs relating to follow-up care under the direction of the program doctors. If a player requires a fourth or subsequent inpatient treatment, 50 percent of the cost of such treatment and related follow-up care shall be paid by the player.

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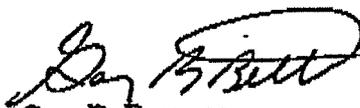
Players who retire from the NHL while in treatment will remain eligible for continued treatment at League expense for a period of up to two years following the player's retirement.

Program doctors may authorize expenses related to any associated costs of care of players, their families or significant others. These expenses will be paid by the player if he is in stage one and will be part of the stipend if the player is in stage two or more.

6. HIV Program

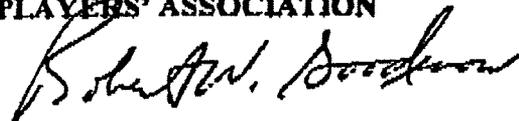
The program doctors will establish a counseling and education program related to HIV/AIDS and other sexually transmitted diseases. The doctors will retain the services of a qualified authority in the field to assist them in the design and implementation of such a program. The parties agree that Dr. Michael Johnson of Mosaic Health Incorporated is an acceptable expert. The program doctors and the HIV expert will develop an appropriate educational program which will be presented to NHL players at least annually. In addition, the program doctors will offer confidential, anonymous and voluntary HIV testing to NHL players and their families, providing that any person volunteering for testing will receive appropriate counseling in connection with such tests. There will be no mandatory HIV screening for NHL players. The cost of this program will be shared equally by the NHL and NHLPA.

AGREED TO AND ACCEPTED:
NATIONAL HOCKEY LEAGUE



Gary B. Bettman,
Commissioner

NATIONAL HOCKEY LEAGUE
PLAYERS' ASSOCIATION


Robert W. Goodenow,
Executive Director and General Counsel

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM



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NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM

Exhibit A:

**COLLECTION AND LABORATORY PROCEDURES
FOR THE NHL/NHLPA SUBSTANCE ABUSE AND
BEHAVIORAL HEALTH PROGRAM**

Definitions.

The following definitions apply to this part:

Alcohol. The intoxicating agent in beverage alcohol, ethyl alcohol or other low molecular weight alcohols including methyl or isopropyl alcohol.

Alcohol use. The consumption of any beverage, mixture or preparation, including any medication, containing alcohol.

Aliquot. A portion of a specimen used for testing.

Blind sample or blind performance test specimen. A urine specimen submitted to a laboratory for quality control testing purposes, with a fictitious identifier, so that the laboratory cannot distinguish it from donor specimens, and which is spiked with known quantities of specific drugs and/or alcohol or which is blank, containing no drugs and/or alcohol.

Chain of custody. Procedures to account for the integrity of each urine specimen by tracking its handling and storage from point of specimen collection to final disposition of the specimen. With respect to drug testing, these procedures shall require that an appropriate drug testing custody form be used from time of collection to receipt by the laboratory and that upon receipt by the laboratory an appropriate laboratory chain of custody form(s) account(s) for the sample or sample aliquots within the laboratory.

Collection container. A container into which the donor urinates to provide the urine sample used for a drug test.

Collection site. A place designated by the program doctors where donors present themselves for the purpose of providing a

specimen of their urine to be analyzed for the presence of drugs.

Collection site person. A person who instructs and assists donors at a collection site and who receives and makes an screening examination of the urine specimen provided by those donors.

Confirmation (or confirmatory) test. In drug testing, a second analytical procedure to identify the presence of a specific drug or metabolite that is independent of the screening test and that uses a different technique and chemical principle from that of the screening test in order to ensure reliability and accuracy. (Gas chromatography/mass spectrometry (GC/MS) is the only authorized confirmation method for cocaine, marijuana, opiates, amphetamines, and phencyclidine.)

Medical Review Officer (MRO). A licensed physician, certified by the American Association of Medical Review Officers (medical doctor or doctor of osteopathy) responsible for receiving laboratory results generated by the drug testing program who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate a donor's confirmed positive test result together with his or her medical history and any other relevant biomedical information.

Screening test (or initial test). In drug testing, an immunoassay screen to eliminate "negative" urine specimens from further analysis.

Shipping container. A container capable of being secured with a tamper-evident seal that is used for transfer of one or more urine specimen bottle(s) and associated

documentation from the collection site to the laboratory.

Specimen bottle. The bottle that, after being labeled and sealed according to the procedures in this part, is used to transmit a urine sample to the laboratory.

SPECIMEN COLLECTION PROCEDURES.

INTEGRITY AND IDENTITY OF SPECIMEN.

Precautions shall be taken to ensure that a urine specimen is not adulterated or diluted during the collection procedure and that information on the urine bottle and on the urine custody and control form can identify the donor from whom the specimen was collected. The following minimum precautions shall be taken to ensure that unadulterated specimens are obtained and correctly identified:

- (1) When a donor arrives at the collection site, the collection site person shall ensure that the donor is positively identified as the person selected for testing (e.g., through presentation of photo identification or identification by a team representative). If the donor's identity cannot be established, the collection site person shall not proceed with the collection. If the donor requests, the collection site person shall show his identification to the donor.
 - (2) If the donor fails to arrive at the assigned time, the collection site person shall contact the appropriate authority to obtain guidance on the action to be taken.
 - (3) The donor shall provide his specimen under the direct observation of the collection site person.
 - (4) The collection site person shall instruct the donor to provide at least 45 ml of urine under the split sample method of collection.
- (A) The collection site person, in the presence of the donor, pours the urine into

two specimen bottles. Thirty (30) ml shall be poured into one bottle, to be used as the primary specimen. At least fifteen (15) ml shall be poured into the other bottle, to be used as the split specimen.

(B) Both bottles shall be shipped in a single container, together with copies and the split specimen copy of the chain of custody form, to the laboratory.

(C) If the test result of the primary specimen is positive, the donor may request that the MRO direct that the split specimen be tested for presence of the drug(s) for which a positive result was obtained in the test of the primary specimen.

(D) If the result of the test of the split specimen fails to reconfirm the presence of the drug(s) or drug metabolite(s) found in the primary specimen, the MRO shall cancel the test.

(E) If the donor is unable to provide an adequate quantity of urine, the collection site person shall instruct the donor to drink not more than 24 ounces of fluids and, after a period of up to two hours, again attempt to provide a complete sample using a fresh collection container. The original insufficient specimen shall be discarded. If the donor is still unable to provide an adequate specimen, the insufficient specimen shall be discarded, testing discontinued, and CDT so notified.

(5) Immediately after the specimen is collected, the collection site person shall measure the temperature of the specimen. The temperature measuring device used must accurately reflect the temperature of the specimen and not contaminate the specimen. The time from urination to temperature measure is critical and in no case shall exceed 4 minutes.

(6) A specimen temperature outside the range of 32°-38°C/90°-100°F, constitutes a reason to believe that the donor has altered or substituted the specimen. In such cases, the MRO must be notified immediately.

- (7) Immediately after the specimen is collected, the collection site person shall also inspect the specimen to determine its color and look for any signs of contaminants. Any unusual findings shall be noted on the urine custody and control form.
- (8) Both the donor being tested and the collection site person shall keep the specimen in view at all times prior to its being sealed and labeled. The specimen shall be sealed (by placement of a tamperproof seal over the bottle cap and down the sides of the bottle) and labeled in the presence of the donor.
- (9) The collection site person shall place securely on the bottle an identification label which contains the date, the donor's specimen number, and any other identifying information provided or required by the program doctors. If separate from the label, the tamperproof seal shall also be applied.
- (10) The donor shall initial the identification label on the specimen bottle for the purpose of certifying that it is the specimen collected from him.
- (11) The collection site person shall enter on the drug testing custody and control form all information identifying the specimen. The collection site person shall sign the drug testing custody and control form certifying that the collection was accomplished according to the applicable program requirements.
- (12) The donor shall be asked to read and sign a statement on the drug testing custody and control form certifying that the specimen identified as having been collected from him is in fact that specimen he provided.
- (13) The collection site person shall complete the chain of custody portion of the drug testing custody and control form to indicate receipt of the specimen from the donor and shall certify proper completion of the collection.

(14) The samples shall be placed in a shipping container with copies 1 thru 3 of the chain of custody form. The shipping container shall be sealed.

(15) The urine specimen and chain of custody form are now ready for shipment. If the specimen is not immediately prepared for shipment, the collection site person shall ensure that it is appropriately safeguarded during temporary storage.

(16) While any part of the above chain of custody procedures is being performed, it is essential that the urine specimen and custody documents be under the control of the involved collection site person.

LABORATORY ANALYSIS PROCEDURES.

(a) CHAIN OF CUSTODY

Laboratories shall use chain of custody procedures to maintain control and accountability of specimens from receipt through completion of testing, reporting of results, during storage, and continuing until final disposition of specimens. The date and purpose shall be documented on an appropriate chain of custody form each time a specimen is handled or transferred, and every employee in the chain shall be identified. Accordingly, authorized technicians shall be responsible for each urine specimen or aliquot in their possession and shall sign and complete chain of custody forms for those specimens or aliquots as they are received.

(b) RECEIVING.

(1) When a shipment of specimens is received, laboratory personnel shall inspect each package for evidence of possible tampering and compare information on specimen bottles within each package to the information on the accompanying chain of custody forms. Any direct evidence of tampering or discrepancies in the information on specimen bottles and the program's chain of custody forms attached to

the shipment shall be immediately reported to the MRO and shall be noted on the laboratory's chain of custody form which shall accompany the specimens while they are in the laboratory's possession.

(2) The laboratory shall log in the split specimen, with the split specimen bottle seal remaining intact. The laboratory shall store this sample securely (see paragraph (c) of this section). If the result of the test of the primary specimen is negative, the laboratory may discard the split specimen. If the result of the test of the primary specimen is positive, the laboratory shall retain in properly secured long-term frozen storage for a minimum of 1 year.

(3) When directed in writing by the MRO, the laboratory shall analyze the split specimen by GC/MS to reconfirm the presence of the drug(s) or drug metabolite(s) found in the primary specimen. Such GC/MS confirmation shall be conducted without regard to the cutoff levels. The split specimen shall be retained in long-term storage for one year by the laboratory conducting the analysis of the split specimen (or longer if litigation concerning the test is pending).

(c) SHORT-TERM REFRIGERATED STORAGE.

Specimens that do not receive an initial test within 7 days of arrival at the laboratory shall be placed in secure refrigeration units. Temperature shall not exceed 6°C. Emergency power equipment shall be available in case of prolonged power failure.

(d) SPECIMEN PROCESSING.

When conducting either initial or confirmatory tests, every batch of specimens shall contain an appropriate number of standards for calibrating the instrumentation and a minimum of 10 percent controls. Both quality control and blind performance test samples shall appear as ordinary samples to laboratory analysts.

(e) INITIAL TEST.

(1) The following initial cutoff levels shall be used when screening specimens to determine whether they are negative for these drugs or classes of drugs.

DRUG	Initial test Level (ng/ml)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites*	300
Phencyclidine	25
Amphetamines	1000
Urine alcohol	.02 %

* 25 ng/ml if immunoassay specific for free morphine.

(2) These drugs and cut off levels are subject to change by the program doctors.

(f) CONFIRMATORY TEST.

All specimens identified as positive on the initial test shall be confirmed using gas chromatography/mass spectrometry (GC/MS) techniques at the cutoff values listed in this paragraph for each drug. All confirmations shall be by quantitative analysis. Concentrations which exceed the linear region of the standard curve shall be documented in the laboratory record as "greater than highest standard curve value."

DRUG	Confirmatory test cutoff levels (ng/ml)
Marijuana metabolites	15
Cocaine metabolites	150
Opiates:	
Morphine	300
Codeine	300
Phencyclidine	25
Amphetamines	
Amphetamine	500
Methamphetamine	500
Urine alcohol	.02%

(g) REPORTING RESULTS.

(1) The laboratory shall report test results to the Medical Review Officer within 1 to 3 working days after receipt of the specimen by the laboratory. Before any test result is reported (the results of initial tests, confirmatory tests, or quality control data), it shall be reviewed and the test certified as an accurate report by the responsible employee. The report shall identify the

drugs/metabolites tested for, whether positive or negative, the specimen number assigned by the program, and the drug testing laboratory specimen identification number (accession number).

(2) The laboratory shall report as negative all specimens which are negative on the initial test or negative on the confirmatory test. Only specimens confirmed positive shall be reported positive for a specific drug.

(3) The laboratory shall send only to the Medical Review Officer the original or a certified true copy of the drug testing custody and control form, which, in the case of a report positive for drug use, shall be signed (after the required certification block) by the employee responsible for day-to-day management of the drug testing laboratory or the employee responsible for attesting to the validity of the test reports, and attached to which shall be a copy of the test report.

(4) Unless otherwise instructed by the program doctors in writing, all records pertaining to a given urine specimen shall be retained by the drug testing laboratory for a minimum of 2 years.

(h) LONG-TERM STORAGE.

Long-term frozen storage (-20° C or less) ensures that positive urine specimens will be available for any necessary retest during administrative or disciplinary proceedings. The laboratory shall retain and place in properly secured long-term frozen storage for a minimum of 1 year all specimens confirmed positive, in their original labeled

specimen bottles. Within this 1-year period, the program doctors may request the laboratory to retain the specimen for an additional period of time, but if no such request is received the laboratory may discard the specimen after the end of 1 year, except that the laboratory shall be required to maintain any specimens known to be under legal challenge for an indefinite period.

(i) RETESTING SPECIMENS.

Because some analyses deteriorate or are lost during freezing and/or storage, quantitation for a retest is not subject to a specific cutoff requirement but must provide data sufficient to confirm the presence of the drug or metabolite.

(j) DOCUMENTATION.

The drug testing laboratories shall maintain and make available for at least 2 years documentation of all aspects of the testing process. This 2-year period may be extended upon written notification by the program doctors. The required documentation shall include personnel files on all employees authorized to have access to specimens; chain of custody documents; quality assurance/quality control records; procedure manuals; all test data (including calibration curves and any calculations used in determining test results); reports; performance records on performance testing; performance on certification inspections; and hard copies of computer-generated data. The laboratory shall maintain documents for any specimen known to be under legal challenge for an indefinite period.

(k) The laboratory will be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), the College of American Pathologists (CAP) or their Canadian equivalents and will participate successfully in the appropriate proficiency testing programs.

QUALITY ASSURANCE AND QUALITY CONTROL.

(a) GENERAL.

The laboratory shall have a quality assurance program which encompasses all aspects of the testing process including but not limited to specimen acquisition, chain of custody, security and reporting of results, initial and confirmatory testing, and validation of analytical procedures. Quality assurance procedures shall be designed, implemented, and reviewed to monitor the conduct of each step of the process of testing for drugs.

(b) LABORATORY QUALITY CONTROL REQUIREMENTS FOR INITIAL TESTS.

Each analytical run of specimens to be screened shall include:

- (1) Urine specimens certified to contain no drug;
- (2) Urine specimens fortified with known standards; and
- (3) Positive controls with the drug or metabolite at or near the cutoff level. In addition, with each batch of samples a sufficient number of standards shall be included to ensure and document the linearity of the assay method over time in the concentration area of the cutoff. After acceptable values are obtained for the known standards, those values will be used to calculate sample data. Implementation of procedures to ensure that carryover does not contaminate the testing of a donor's specimen shall be documented. A minimum of 10 percent of all test samples shall be quality control specimens. Laboratory quality control samples, prepared from spiked urine samples of determined concentration shall be included in the run and should appear as normal samples to laboratory analysis. One percent of each run, with a minimum of at least one sample, shall be the laboratory's own quality control samples.

(c) LABORATORY QUALITY CONTROL REQUIREMENTS FOR CONFIRMATION TESTS.

Each analytical run of specimens to be confirmed shall include:

- (1) Urine specimens certified to contain no drug;
- (2) Urine specimens fortified with known standards; and
- (3) Positive controls with the drug or metabolite at or near the cutoff level. The linearity and precision of the method shall be periodically documented.

Implementation of procedures to ensure that carryover does not contaminate the testing of a donor's specimen shall also be documented.

(d) BLIND PERFORMANCE TEST PROCEDURES.

Urine specimens will be submitted to the laboratory for quality control testing purposes, with fictitious identifiers, so that the laboratory cannot distinguish them from donor specimens. The specimens will be spiked with known quantities of specific drugs or blanks, containing no drugs.

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM**Exhibit B:****Mental Health/ Substance Abuse Assessment****Reason for Consultation****Presenting Mental Health Concern (s)****History of Mental Health Concern (s)****History of Substance Use****Family History of Mental Health Problems****Family History of Substance Use Problems****Previous Treatment for Mental Health Problems****Previous Treatment for Substance Use Disorder****Medical History and Review of Systems****Complete Physical Examination****Laboratory Battery Including:****Complete Blood Count****Electrolytes****Renal Function Tests****Liver Function Tests****Thyroid Function Tests****Cholesterol and Triglycerides****PSA****RPR/VDRL****Hepatitis Screen****Personal History****Mental Status Examination****Test Results****DSM-IV Multi-axial Diagnostic Formulation****Recommendations**

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM**Standardized Substance Use and Mental Health Assessment
for NHL Players and their Family Members****A. Substance Use Problem**

The assessment of alcohol and other drug problems will consist of the following components: a description of the problem (including diagnosis), an evaluation of its severity (which includes consequences of drug and alcohol use), and a functional analysis (the conditions under which it is most likely to occur). The information will be gathered preferably while the client is drug-free, not in withdrawal, with the assurance of confidentiality, in a professional manner, under conditions of good rapport, and with the understanding that multiple sources of information will be collected. The following represent reliable and valid methods of assessing these components:

Screening of Alcohol Problems

The CAGE is a widely used screening instrument to detect potential alcohol problems. It is fairly sensitive to alcohol problems and is easily self-administered as it consists of 4 items. The Alcohol Use Identification Test (AUDIT), a 10-item screening test with good sensitivity and specificity will also be used in clinical assessments.

Description of Substance Use Problem

(i) The Timeline Follow-back Method (TFLB) requests the client to provide exact levels of consumption of a drug over a specified period of time (e.g., 30, 60 or 90 days). The advantage of the TFLB is that it provides a fairly exact representation of drug consumption which can be compared to post-treatment levels. General estimations of frequencies of alcohol or drug use which are commonly used may mask heavy drinking episodes and collapses patterns of drinking into single-point estimations.

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(ii) The Pretreatment Drug History questionnaire evaluates the major drug classes (i.e., alcohol, stimulants, depressants, opiates, hallucinogens, tranquilizers) in terms of lifetime use, age of first use, years used, recent use, degree of problem level, focus of treatment, prescribed. This questionnaire provides an overview of significant lifetime alcohol and drug use and will include the assessment of over-the-counter substances as well.

(iii) Biochemical measures such as breath, urine and blood tests assess recent drug or alcohol use but provide very little information about severity of the problem or levels of consumption. They may be a component of a treatment intervention and if used, they will be administered randomly.

Severity of Drug and Alcohol Use

(i) The Alcohol Dependence Scale (ADS) provides a measure of the severity of the alcohol problem. The ADS may be used to assess the effects of treatment and at follow-up assessment.

(ii) The Drug Abuse Screening Test (DAST) provides a measure of the severity of non-alcohol problem. The DAST may be used to assess the effects of treatment and at follow-up assessment.

Functional Analysis

(i) The Inventory of Drinking Situations (IDS) is a measure of the situations that are most frequently associated with alcohol misuse and may aid treatment planning since it can identify critical high-risk situations. A similar instrument, the Inventory of Drug-Taking Situations (IDTS) may be used with drugs other than alcohol.

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(ii) The Situational Confidence Questionnaire (SCQ) is based on the IDS and provides a measure of the confidence or self-efficacy the client believes they possess in resisting the urge to drink in high-risk situations. The SCQ may be used as a measure of treatment effectiveness. A similar instrument, the Drug-Taking Confidence Questionnaire (DTCQ) may be used with drugs other than alcohol.

(iii) The Coping Behavior Inventory (CBI) measures the effectiveness of a large number of coping behaviors in situations where drinking is likely. This instrument may be used to aid in the treatment-planning process and to measure the effect of treatment.

B. Mental Health Assessment

Clinical Interview

An overview of the client's personal history will survey major life events, early family, academic and social history, contact with mental health services, history of mental health and substance problems and treatment, family history of mental health and substance problems, leisure activities, career development, medical history, strengths and assets, and mental status. This information will provide the necessary context within which to interpret the test findings and can help develop appropriate treatment recommendations given the client's individual needs. The Dyadic Adjustment Scale (DAS) may be used to assess marital adjustment and is also useful with substance-abusing clients.

Diagnostic Interview

The Structured Clinical Interview for DSM-IV (SCID) is a widely used schedule which permits the diagnosis of any clinically significant mental health problem (including drug and alcohol problems). It is likely that the anxiety, mood, and psychoactive substance use modules will be the most important components of the interview to administer for most clients; however, any DSM-IV category can be diagnosed using this instrument.

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM**Current Mental Health Status**

The Symptom Checklist-90 (SCL-90) is a widely used measure of current mental health (i.e., within the past week) and is highly sensitive to treatment effects. Since depression tends to be very common in individuals who are experiencing mental health or substance use problems the Center for Studies-Depression Scale (CES-D) is a valuable measure of depression, especially in individuals who are also experiencing alcohol or drug problems. The Beck Depression Inventory (BDI) may also be employed.

Dr. David Lewis**Dr. Brian Shaw**

NHL/NHLPA SUBSTANCE ABUSE AND BEHAVIORAL HEALTH PROGRAM

EXHIBIT C:

**A) CONSENT FOR RELEASE OF SUBSTANCE
ABUSE PATIENT INFORMATION OR
RECORDS**

**B) RESPONSE TO REQUEST FOR
CONFIDENTIAL INFORMATION**

C) RECORD RELEASE FORM

CONSENT FOR RELEASE OF SUBSTANCE ABUSE PATIENT INFORMATION OR RECORDS

I hereby authorize [name of organization conducting program] _____
_____ to disclose records obtained in the course of the diagnosis and treatment of
[name of patient] _____ for alcohol and/or drug abuse to
[name of person or organization to which disclosure is made] _____

The disclosure of records authorized herein is required for the following purpose: _____
_____; and such disclosure shall be limited to the following
specific types of information: _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken
in reliance hereon, and if not earlier revoked, it shall terminate on [date, event, or condition] _____
_____ without express revocation.

Date: _____ Time: _____ A.M./P.M.

Signature: _____
[patient/patient's guardian/conservator/guardian]

If signed by other than patient, indicate relationship: _____

Witness: _____

RESPONSE TO REQUEST FOR CONFIDENTIAL INFORMATION

Re: Records of _____
[name of patient]

Dear Sir or Madam:

By letter of [date] _____, you have requested information from the records of the above-named patient.

Pursuant to state and federal law, records which contain information pertaining to the diagnosis or treatment of psychiatric, alcohol- or drug-related disorders are subject to strict confidentiality.

The records you seek may contain information which falls within this category, and we cannot release the records to you without specific written authorization by the patient. If you wish, we will send you a form which may be completed by the patient to authorize release of any such records.

Date: _____

Signature: _____
[medical records]

RECORD RELEASE

Patient's Name: _____

Patient Number: _____

On (date) _____, information from the record of the above-named patient was released to:

[name of person or agency to whom information was released]

[person's relationship to patient, or agency person represents]

The release was made under the following circumstances:

- (a) Written authorization by patient;
- (b) Written authorization by parent, guardian, or conservator;
- (c) Family was notified that patient was seriously ill. Release was authorized by (name of physician) _____;
- (d) Patient left facility without notice, and is adjudged to be a danger to self or others or gravely disabled. Release was authorized by (name of physician) _____;
- (e) Patient believed to have committed or to have threatened to commit or to have been a victim of a crime, while hospitalized.
- (f) Other: _____

Nature of information released: _____

Date: _____

Signature: _____

Title: _____