SUBSTANCE USE TESTING
CONSENT FORM

I hereby certify that I have reviewed a written copy of **(Clinic Name)** _____Drug-Free Workplace Policy which was effective **(Implementation Date)** _____. I have been given the opportunity to ask questions regarding this policy. I understand that violation o this policy is cause for disciplinary action, up to and including termination, or disqualification of employment.

I hereby give my voluntary consent for specimen(s) to be collected from me and submitted for drug and/or alcohol testing as a condition of my initial or continued employment. I understand that I will not be forced to submit to any alcohol or drug test, but my refusal to do so shall result in termination of employment or consideration for employment. I further consent to the release of said test results to **(Clinic Name)** _____and the said employer's Medical Review Officer. I understand that these results will be held in strict confidence.

I understand that **(Clinic Name)** _____ has the right to conduct searches and inspections of any employee's personal effects, clothing, work area, and vehicle for the purpose of determining if such employee or other person is in possession, uses, transports, or conceals any prohibited items and/or substances.

Searches, inspections, and substance use testing as may be required from time to time without prior announcement shall be conducted with concern for the personal privacy of each employee.

I understand that consent and cooperation in these procedures is a condition of employment, and that refusal to consent may result in termination or disqualification from employment.

I authorize the release of any test results to the company's workers' compensation insurer(s), the Alabama Unemployment Compensation Division, or any other government agency investigating my employment or termination.

I understand that copies of this original shall have the same force and effect as the original.

I understand that this agreement in no way limits my rights or **(Clinic Name)** to terminate employment at any time for any reason.

_____ _____
PRINT NAME **SOCIAL SECURITY NUMBER**

_____ _____
EMPLOYEE'S (APPLICANT) SIGNATURE **DATE**

_____	_____
WITNESS' PRINTED NAME	**TITLE**