

AUTHORIZATION FORM

Person requesting the test is to fax copy of this request to:

C D T SERVICES 806-934-5578

Company: _____ **Phone:** _____ **Date:** _____

Donor: _____ **SS#** _____

Time Issued: _____ **am pm**

PLEASE CHECK APPROPRIATE () SPACE BELOW

DRUG

Type of Test

- Non-Dot Drug
- DOT Drug
- Hair Drug Test
- Other
- 10 PANEL QUICK TEST
- 5 PANEL QUICK TEST

Reason for Test

- Pre-employment
- Random
- Post-Accident
- Reasonable Cause
- Return - To - Duty
- Follow-up
- Pre-access

ALCOHOL

- Non-Dot Alcohol
- DOT Alcohol
- Non-Dot Scan

- Random
- Post-Accident
- Reasonable Cause
- Return - To - Duty
- Follow-Up
- Pre-Access

Billing (check if applicable)

Employee to pay charges

EMPLOYEE MUST HAVE A GOVERNMENT ISSUED PHOTO I.D., Social Security number, and this Authorization form in order to begin testing. FIT Testing requires an appointment. Do not drink more than 24 oz of fluids before arriving for a UA.

Statement of Notification (To be signed by the individual responsible for notifying the employee of random testing requirements):

I have notified the above employee of their selection to submit to random drug and/or alcohol testing. The employee has been advised that they have 30 MINUTES PLUS TRAVEL TIME to arrive at the designated collection site. Employee has been notified that failure to do so will be considered a REFUSAL TO TEST and may result in disciplinary action up to and including termination of employment.

Signature of Supervisor Responsible for Notification