St. Clair County Community Mental Health

Drug Testing:
Consent to Diagnostic Procedure & Release of Information Authorization

I,_____, voluntarily authorize the Department of Transportation (DOT) and such assistants or physicians as they may designate to perform an alcohol level and drug screen upon myself.

I authorize the results of this examination to be released to St. Clair County Community Mental Health.

I understand that an interpretation of such results will be used only to assist in the evaluation of my ability to adequately perform the duties of the job for which I have applied or to which I have been assigned.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Original: Personnel File
cc: Employee
CMH Administrative File