LOCAL 103

GenTox eCCF Lab Code
QUEST 11695992
Split Specimen preferred

Consent to Drug/Alcohol Test

Name: ____ **Date of Birth:** __________________________

Address: ____________________________________ **City:** ___________________ **State:**_______ **Zip:** _______

Cell Phone : ___________________________________ **email:**____

Photo Identification: **State Driver's License** **Company ID** **CCS** **Other** ___________________________

Social Security Number: _____________________________ **CCS Number:** ___________________________

Contractor: __________________________________ **Traveler Local Number** ______________________

Bargaining Member: YES_____ NO_____ **Specimen Collection Observed YES_____ NO_____**
DOT Drug Test: YES_____ NO_____

Reason for Test: Pre-Employment ____ Annual ____ Random ____ Post-Accident ____

Reasonable Suspicion ____ Job Site Admission ____ Other _____________________

I, ____, hereby knowingly and voluntarily authorize and consent to the collection of urine, and/or breath for the purpose of testing for the presence of prohibited drugs and/or alcohol.
I hereby authorize and direct the collection facility employee(s) or agent(s) to release my test results to my employer or contractor, and/or authorized agent.
I agree to forever release and hold harmless the collection facility and the authorized parties entitled to the information from any and all liability whatsoever arising from the collection of my sample(s) and releasing the result of my drug/alcohol screening test to the above-named employer and/or contractor.
I understand that this authorization to release test results will expire (180) days from the date appearing on this form, and that I may revoke this authorization at any time. In no event will the expiration of one hundred eighty (180) days have any effect upon the release from liability or waiver of privacy. The fact that my information exists after the one hundred eighty (180) day period with any third party is in no way affected since it was released with the proper period of time allowed by this release.
I understand a documented chain of custody exists to ensure the identity and integrity of my specimen(s) throughout the collection and testing process.
I am authorizing the Medical Review Officer and/or the Medial Review Officer Assistant to electronically access and view my current prescription medication in the event I have a non-negative test result. This consent is authorized for 10 (days) only from today's date.

____
Donor Initials

Donor Signature: ____

Date: _____________ Time: _____________

Collector Name: ______________________________ Collector Signature: _______________________

Attention Collection Locations: This form and the completed Chain of Custody form must be mailed to GenTox LLC 1602 N. Fares AV. Evansville, IN. 47711. Failure to mail the original copies within 30 days will result in non-payment. Please fax or email copies immediately following the collection to 812-437-7155 or gentoxunion@gentoxin.com

YOU MUST HAVE THIS CONSENT FORM TO TEST