Occupational Medicine

Phone (843) 402-5053 - Fax (843) 402-5054

Consent: Drug Screening

Employee Name	DOB

- I hereby, freely and voluntarily, consent to the collection of urine, breath, saliva, hair and/or blood by the Roper St. Francis Healthcare Occupational Health Partners, to determine the presence of illegal drugs, alcohol or other controlled substances.
- I further authorize the laboratory or other testing entity to release the results to Occupational Health Partners or its designated agent(s), or to my current and prospective employer.
- All physicians, employees and agents who work or perform services for any of the above entities are held harmless from any action that may arise out of such test results being divulged to the above name entities.
- **Roper St. Francis Healthcare Occupational Health Partners licensed or registered employees and applicants:** Positive results for illicit drugs or drugs for which authorized prescriptions cannot be substantiated or alcohol (except for applicants), or refusal to provide a valid specimen, will be reported to the appropriate State Licensing Board or Registry.

Name ____ SSN _________________

Signed ____ Date ______________

Witness____ Date ______________

If Under 18, Parental Consent Is Required

Name Parent or Guardian ____ Date ______________

Signed ____ Date ______________

Refusal to Test:

- I do not give my consent for the collection of urine, breath, saliva, hair and/or blood to determine the presence of illegal drugs, alcohol or other controlled substances.
- Refusal to give consent will result in immediate termination of the employment assessment.

Name _________________________________SSN _________________ Birth Date ____/____/______

Signed ____ Date ____/____/______

Witness____ Date ____/____/______