METHODIST LE BONHEUR HEALTHCARE
CONSENT FOR DRUG AND/OR ALCOHOL SCREEN

NAME: _____DATE OF BIRTH _____
(PLEASE PRINT)

Have you taken medication or drugs in the past 30 days? Yes _____ No _____

Have you used any illegal drugs in the past 30 days? Yes _____ No _____

Are you taking medication, prescription or non-prescription? Yes _____ No _____

If yes to any of the above, list names of all drugs and/or medications:

_____

_____

_____

I hereby consent and agree to give a sample of my urine and/or blood for alcohol/drug screening at the request of Methodist Le Bonheur Healthcare. Results of any tests performed shall be provided to Human Resources - Associate Health Services. My signature below acknowledges that I have read and understand the foregoing statement, and I have answered all the questions truthfully. I also acknowledge that any medications that I have taken within the last 30 days have been listed above.

_____ _____
Signature Date

_____ _____
Supervisor or Associate Health Nurse Date

REFUSAL FOR DRUG AND/OR ALCOHOL SCREEN

I refuse to be tested for alcohol/drug use and acknowledge such unreasonable refusal may be grounds for termination of my employment.

_____ _____
Signature Date

_____ _____
Supervisor or Associate Health Nurse Date