**Drug Testing Consent Form**

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| **Request Information** | | | |
| Requesting Company: | | | |
| Collection Location: | | | |
| Sample ID: | | Date: | |
| **Employee Information** | | | |
| Full Name: | | | |
| Date of Birth: | | Gender: | |
| OPTIONAL: List all the medications in the past 72 hours that may affect the results of your test. | | | |
| **Medication Name** | **Medication Quantity** | | **Date Taken** |
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| **Declaration of Consent** | | | |
| I consent to the collection and analysis of my breath/urine/oral fluid for the purpose of screening for prohibited substances.  I consent to my test results being released to the requesting company.  I confirm that the employee information and sample I have provided are my own. | | | |
| Signature: | | Date: | |
| **Test Company Details** | | | |
| Testing Company: | | | |
| Lab Location: | | | |
| Phone: | | Email: | |