**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: |