

**CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING**

I understand that submission to a Post-Injury Drug And/Or Alcohol Screen is a condition of employment with this employer. I understand that, should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action, including possible discharge. I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's Workers' Compensation Law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action, including possible discharge.

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant S/ S#: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant S/ S#: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_