Tri-State Occupational Health

4155 Pennsylvania Avenue • Dubuque, IA 52002
563-584-4600 • 800-637-2959 • Fax 563-582-7847

DRUG & ALCOHOL TESTING AUTHORIZATION FORM

(Must have valid billing information on file with collection site prior to appointment and form provided at appointment)

Donor (Applicant/Employee) Name: _____

DOB/Other Identifier: _____ Last 4 of SSN: _____

Company: _____ Date of Appointment: _____

You are authorized to perform the following substance abuse testing for the above-mentioned individual:

SPECIFY DRUG TESTING TO BE PERFORMED (check all that apply):

☐ URINE DRUG SCREEN ☐ SALIVA DRUG SCREEN ☐ RAPID URINE DRUG SCREEN
☐ RAPID SALIVA DRUG SCREEN ☐ HAIR COLLECTION ☐ BREATH ALCOHOL
☐ SALVIA ALCOHOL **ensure collection site has staff trained/certified for specific test(s) requested.*

SELECT TESTING AUTHORITY: *(ensure proper forms are supplied)*

☐ NON-DOT ☐ DOT

SPECIFY TESTING AUTHORITY (if applicable):

☐ HHS ☐ NRC

SELECT AGENCY (if applicable):

☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

SELECT REASON FOR TEST:

☐ PRE-EMPLOYMENT ☐ RANDOM ☐ REASONABLE SUSPICION/ CAUSE
☐ POST ACCIDENT ☐ RETURN TO DUTY ☐ FOLLOW-UP
☐ OTHER (please specify): _____

CONFIRM TESTING TO BE PERFORMED:

PLEASE SPECIFY PANEL SIZE: _____ (e.g., 5-Panel, 10-Panel, etc.)

SPECIAL INSTRUCTIONS/ COMMENTS: _____

_____

Please send complete Custody and Control Forms (CCF) to:

DER	MRO	C/TPA
DER Name: _____.	MRO Name: _____.	C/TPA Name: _____.
DER Phone Number: _____.	MRO Phone Number: _____.	C/TPA Account/ Client ID: _____.
DER Fax: _____.	MRO Fax: _____.	
DER Email: _____.	MRO Email: _____.	Lab
How to send CCF:	How to send CCF:	Lab Used: _____.
☐ Email ☐ Fax ☐ Mail	☐ Email ☐ Fax ☐ Mail	

Authorized By: _____ Job Title: _____ Date: _____

Company requesting and authorizing testing is to ensure collection site has appropriate testing supplies and forms.