St. Clair County Community Mental Health Authority

# Drug Testing:
# Consent to Diagnostic Procedure & Release of Information Authorization

I,_____, voluntarily authorize the Department of Transportation (DOT) and such assistants or physicians as they may designate to perform an alcohol level and drug screen upon myself.

I authorize the results of this examination to be released to St. Clair County Community Mental Health.

I understand that an interpretation of such results will be used only to assist in the evaluation of my ability to adequately perform the duties of the job for which I have applied or to which I have been assigned.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Original: Personnel File
cc: Employee
CMH Administrative File

Sup Form: #12-0732
Reviewed Date: 7/1/2023
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