

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCE CENTER
HEALTH CARE SERVICES DIVISION**

Substance Abuse and Drug Free Workplace Policy Consent Form

I have been requested to submit to a pre-employment drug screen urine test for employment at _____ Medical Center/Headquarters.

I have been informed and I understand that my agreement to submit to the requested pre-employment drug screen urine test is completely voluntary on my part, and that I have the right to refuse to submit to the test. I am aware and have been told that my refusal to submit to the drug screening or the result of a confirmed positive by a urine test will disqualify me for employment or appointment. A prospective employee who declines to consent to screening or who receives a confirmed positive drug test result shall be subject to disqualification from employment for a period of one year from the effective date of the disqualification action. A prospective employee who intentionally tampers with a sample provided for drug screening, violates the chain of custody or identification procedures, or falsifies test results shall be subject to disqualification from employment for a period of three years from the effective date of the disqualification action.

I hereby give my consent to LSU Health Science Center - Health Care Services Division (LSUHSC-HCSD) and their agents to perform this test. I hereby authorize the MRO who will receive the results of my drug and/or alcohol test to disclose the results of the test(s) to the appropriate Human Resource Director, or his/her designee, and my supervisor, as appropriate, for the purpose of determining the appropriateness of my eligibility for, or continued employment. I further authorize the above individuals or his/her designee to disclose those results to the Human Resource Director or his/her designee, of other divisions, hospitals, or facilities within the LSU Health Sciences Center, and to other state and federal agencies, including the Department of State Civil Service, if appropriate.

I understand that the MRO may inform the appropriate Human Resource Director, or his/her designee, and my supervisor, of any legally obtained prescription medication I may be taking if it is felt that the usage of this medication(s) can or has compromised my fitness for duty in my capacity as an employee.

I also understand that withdrawal of this permission prior to, or any time after, the release of the results of the alcohol and/or drug test to the above named individuals may be grounds for termination of my employment.

I acknowledge that I have been advised that I may make a written request for a complete and accurate disclosure of the nature and scope of the tests conducted.

Employee Name (Please Print)

Employee Signature

Date

Drug Testing Coordinator

Date