# PERSONNEL 03.13251 AP.2

Drug Testing Forms

Employee Acknowledgement of Understanding

 Regarding Drug and Alcohol Testing

 I acknowledge that I have received a copy of the applicable Drug Free/Alcohol Free Schools Policy (03.13251 and 03.23251).

 The Board may require that I be tested for drugs or alcohol at any time if there is reasonable suspicion that I am under the influence of illegal drugs or alcohol. I authorize the release of the results of the test to authorized officials of the District and its designated or professional representatives.

 I recognize that if I test positive for illegal drugs or alcohol or adulterate a test sample, this shall be cause for disciplinary action up to and including termination. I also understand that my failure or refusal to cooperate fully and participate in District’s drug and alcohol testing program, sign any required document, or submit to a drug or alcohol screening test if I am selected will result in disciplinary action up to and including termination.

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Signature

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Date

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Witness

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Date

# PERSONNEL 03.13251 AP.2

#  (Continued)

Drug Testing Forms

Todd County School District

Drug Screen Acknowledgement

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Name of Applicant (Please Print)

 I understand that in accordance with the policies of the Todd County Board of Education (Board) of providing and maintaining a safe and healthful working environment for all employees that I as an applicant for employment in a safety sensitive position with the Board am required to submit to a drug screen test.

 I hereby state my willingness to undergo a drug screening examination. I fully understand and accept the condition that any false answers or willful omission made by me in connection with the testing process will automatically disqualify me from further consideration for employment with the Board and if hired will be grounds for disciplinary action up to and including termination if it is later determined that the information I submitted was false.

 I hereby authorize the release of the results of the test to officials of the District and its designated medical or professional representatives. I also authorize the release of the medical records and/or other information to the District’s Medical Review Officer (MRO) to verify the results of the drug screening examination.

 I recognize that if I test positive for illegal drugs or adulterate a test sample, I will not be eligible for employment. I also understand that my failure or refusal to cooperate fully and participate in District’s drug and alcohol testing program, sign any required document, or submit to a drug screening test will render me ineligible for employment.

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Signature

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Date

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Witness

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Date

Review/Revised:8/9/10