THE OHIO STATE UNIVERSITY

Drug-Free Workplace Policy 7.30 Reasonable Suspicion Testing Consent Form

Applies to: Faculty, staff, graduate associates, and student employees

I, _____(individual name), as an employee, graduate associate, or student employee of The Ohio State University, have been informed that:

1. An individual may not be in violation of the Drug-Free Workplace policy.
2. An individual may be asked to submit to a drug/alcohol test if reasonable suspicion exists that an individual may be in violation of the Drug-Free Workplace policy.
3. I have been asked to submit to a drug/alcohol test to determine if I am in violation of the university Drug-Free Workplace Policy.
4. The test will include a request for a urine sample and a breath alcohol test.
5. I may be transported to and from a designated location where the specimens will be collected.
6. The test results will be provided to the university Medical Review Officer.
7. A positive test could result in corrective action up to and including termination of employment.
8. I may refuse my consent to submit to the drug/alcohol test.
9. I will be subject to the corrective action up to and including termination if I refuse the screening or test, adulterate or dilute the specimen, substitute the specimen, send an imposter, or refuse to cooperate in the testing process in such a way that prevents completion of the test.

Individual's statement regarding allegation: _____

_____

_____

_____

_____

At the conclusion of this process, I will be instructed to make arrangements for my safe transportation home and that my supervisor may notify the police if I attempt to operate a vehicle.

I have read the form and **agree** to undergo testing for drugs and/or alcohol _____ _____
(Employee/GA/Student EE signature) (Date)

I have read the form and **refuse** to undergo testing for drugs and/or alcohol _____ _____
(Employee/GA/Student EE signature) (Date)

Witnessed by (signature): _____ **Date:** _____ **Time:** _____ a.m./p.m.

(Printed name): _____ **Title:** _____

Witnessed by (signature): _____ **Date:** _____ **Time:** _____ a.m./p.m.

(Printed name): _____ **Title:** _____

Fax all documentation to 614-293-8018 to "University Health Services – Attn: Medical Review Officer"
Or bring to University Health Services – 2100 Cramblett Hall, 456 W. 10th Ave, Columbus, OH 43210.
For questions, call 614- 293-8146.