



TAYLOR COUNTY SCHOOL DISTRICT
DRUG-FREE WORKPLACE TESTING PROGRAM

DONOR NAME _____

DONOR SS # _____

TEST # _____

TYPE OF TEST:

_____ COVERED EMPLOYEE (DOT)

_____ DRUG TEST-URINE

_____ NON-COVERED EMPLOYEE

_____ ALCOHOL TEST-BREATH

REASON FOR TEST:

_____ PRE-EMPLOYMENT

_____ RETURN TO DUTY

_____ REASONABLE SUSPICION

_____ RANDOM

_____ POST ACCIDENT

_____ OTHER: _____

I UNDERSTAND THAT I MUST REPORT FOR A DRUG/ALCOHOL TEST NO LATER THAN 15 MINUTES. I ALSO UNDERSTAND THAT I MUST HAVE A PHOTO I.D. AND THIS COMPLETED FORM TO PRESENT TO THE TESTING SITE PERSONNEL.

REPORT TO: _____

TIME: _____ DATE: _____

SIGNATURE OF SUPERVISOR

SIGNATURE OF DONOR