Code No. **403.7E4**

DRUG/ALCOHOL TEST NOTIFICATION FORM

_____
Date

_____ _____
Name (print) Social Security Number

The above named employee is to have the following test:

_____ Drug _____ Alcohol _____ Both Drug and Alcohol

Type of Test _____ Random _____ Pre-employment (drug only)

_____ Post-accident _____ Reasonable Suspicion

_____ _____
Time Sent by District School District Contact Person (Phone)

_____ _____
Time Arrived at Collection Site Collection Site Person

_____ _____
Time Test Was Completed Collection Site Person

I understand I am to go directly to the collection site located at:

_____
Address of Collection Site

I understand a positive drug test result or an alcohol test result of .04 alcohol concentration or greater will result in termination of my employment and that an alcohol test result of greater than .02 but less than .04 alcohol concentration requires me to cease performing a safety-sensitive function for twenty-four hours.

I further understand my drug and alcohol testing results are reported to and maintained by the School District and the Iowa Drug and Alcohol Testing (IDATP) medical review officer for the purpose of completion of reports including, but not limited to, the Annual Summary/MIS reports required under the federal drug and alcohol testing regulations.

_____ _____
Employee's Signature Date