Name (print):_____
SS#:_____

For Office Use Only
_____
_____

Driscoll Children's Hospital

Authorization and Release to Test

I hereby consent to let any necessary samples of hair, blood, breath, fingernails, or urine be taken and tested by a laboratory designated by Driscoll Children's Hospital (the "Hospital") to determine the current illegal use of drugs, and/or the presence of alcohol in my system. (Applicants will not be tested for the presence of alcohol.)

I understand that any offer of employment that I receive is contingent upon a negative drug test (as defined by the Hospital's Alcohol and Drug Abuse Guidelines).

I hereby authorize the Hospital to take the above samples and to perform any test to make the above determination. I agree to cooperate in the taking and testing of such samples. I also authorize the release of the results of such tests to Hospital management officials.

I understand that refusal to cooperate in giving any samples (including signing this Authorization and Release to Test) as required will result in my ineligibility for employment with the Hospital or my termination from employment with the Hospital. I also understand that the results of these tests will be used to determine my eligibility or continued suitability for employment with the Hospital and my compliance with the Alcohol and Substance Abuse policy. I understand that I may refuse to be tested. However, I also understand that my employment with the Hospital may be terminated if I refuse such testing.

I hereby release the Hospital and laboratory performing the testing and their officers, directors, employees, attorneys, representatives, and/or agents from any and all liability arising out of the taking or testing of any samples and/or communicating the test results pursuant to this authorization and release.

I understand that as an employee of the Hospital, I am subject to further substance abuse testing, including but not limited to, reasonable suspicion and random testing. I also understand that my employment with the Hospital may be terminated if I refuse such testing.

I understand that this testing authorization and release does not constitute an employment agreement or contract with the Hospital.

I have signed this authorization and release voluntarily and of my own free will.

Signature:_____ Date:_____