NOTIFICATION TO TEST
ALCOHOL AND/OR CONTROLLED SUBSTANCE

State Department of :_____

Employee/Applicant Name (Print First, M.I. Last): _____

You are hereby notified of the requirement to test pursuant to the Drug and Alcohol Testing

Agreement of: BU ___; ☐ CDL ☐ HGEA ☐ UPW ☐ HRS 78-2.6.

Cost of test paid by: ☐ applicant ☐ employee ☐ department

1. The test is scheduled: **Date:** _____

Location: _____

Appointment Time: _____

2. Test for: ☐ Alcohol ☐ Controlled Substance

3. Type of test: ☐ Pre-Employment ☐ Prior to Recruit Training

☐ Post Recruit or Prior to Assigned Workplace ☐ Probationary

☐ Random ☐ Return to Duty ☐ Follow-up

☐ Post-Accident ☐ Post-Altercation ☐ Reasonable Suspicion

☐ Other (please specify) _____

4. Employee/Applicant has picture identification card: ☐ Yes ☐ No

5. Transportation to test site or appointment instructions/comments:

_____

_____

6. Time of notification: _____ a.m. p.m.

I understand that the identified test is required and if I refuse to sign this form or refuse to take the tests identified, I am subject to consequences as stated in the Agreement. Applicants who refuse to sign are removed from the list of eligibles.

☐ I received the Refusal to Test flyer (BU1 Non CDL)

_____ _____

Employee/Applicant Signature Date

_____ _____

Department Representative Date

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE