ASSURED NURSING
18725 N. Union St.
Westfield, IN 46074
Office: 317-862-8141
Fax: 317-862-8143

# Drug Testing Authorization and Consent Form

| Date | Employees Name | DOB | Phone |
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| Full Address | Email |
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I, the undersigned, hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens of my urine by a collection site and laboratory to be designated by **Assured Nursing, Inc.** for the purpose of a 10-panel drug testing.

I understand that the drug and addictive substance testing intended to be performed may include the following: Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids/Marijuana (THC), Hashish, Cocaine Metabolites, Demerol (Meperdine), Fentanyl, Methadone, Methaqualone, Opiate Metabolites, Oxycotin, Hydrocodone, Codeine, Morphine, Opium, Percodan, Phencyclidine (PCP), Propoxyphene, Tramadol, Nicotine, and Alcohol.

I authorize the collection site, laboratory and medical review officer (MRO) to disclose the results of my drug tests to **Assured Nursing, Inc.**

I acknowledge that the drug test results will be utilized by **Assured Nursing, Inc.** to determine my eligibility for employment or continued employment, therewith.

I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my urine by the collection site and laboratory, or a refusal to authorize the above disclosure of the test results will be treated as a positive drug test. I further acknowledge that a positive drug test will result in disciplinary action up to and including denial of employment or termination, if hired.

In addition, I hereby knowingly and voluntarily release **Assured Nursing, Inc.**, the collection site, the testing laboratory and their respective officers, directors, employees and agents from any and all claims, damages, losses, liabilities, costs and expenses, including attorney fees, arising from or relating to such collection and testing and any disclosure of the results thereof, including without limitation, the disclosure of any inaccurate or incomplete results, to the fullest extent permitted by law.

I further authorize the testing laboratory to disclose the results of my drug screen to **Assured Nursing, Inc.**, or its agents for a period of time not to exceed two years from the date of my signature below.

I acknowledge that I have the right to receive a copy of this authorization.

I have read and understood the above Authorization & Consent in its entirety, and I agree that a copy of this document is as valid as the original.

| List of Prescription Drugs Prescribed |
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| Applicant's Signature | Applicant's Signature Date |
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| Recruiters Signature if appliant refuses test | Recruiters Signature Date |
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