M D MEDICAL CLINICS
Occupational Services

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DRUG / ALCOHOL SCREENING CONSENT FORM

I _____ do hereby authorize MD Medical Clinics, its parent corporation or their affiliates or subsidiaries, or any other doctor, clinic, laboratory or medical facility designated by it, to collect urine, breath, blood or other samples for drug/alcohol screening as required.

I understand that all drug/alcohol screening test results and evaluations will not be considered confidential medical information by the medical department and may be discussed with and/or made available to Company Management and/or the agent(s) for the Company.

I further understand, in accordance with the Company's Statement of Policy on Drug/Alcohol Abuse, that the results of this testing may affect my job status with the Company.

Date_____ Signature_____

Social Security# _____ Witness_____

PLEASE PRESENT YOUR PHOTO ID TO BE PHOTOCOPIED.

REMOVE ANY OUTER GARMENTS AND LEAVE ANY PERSONAL BELONGINGS OUTSIDE THE COLLECTION AREA. YOU MAY RETAIN YOUR WALLET OR VALUABLES.

YOU WILL BE ASKED TO PROVIDE A ***URINE*** SAMPLE BY THE COLLECTOR. IF THE SPECIMEN DOES NOT MEET THE STRICT TEMPERATURE REQUIREMENTS, OR IF A SPECIMEN HAS BEEN ALTERED IN ANY WAY, A SECOND ***OBSERVED*** SAMPLE WILL THEN BE COLLECTED.

"Keeping You on Your Job is Our Job"