



**AFTER HOURS DRUG AND ALCOHOL TESTING**

**Phone: 813-924-6678**

**AUTHORIZATION**

**Date:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Company Contact Name:** \_\_\_\_\_

**Company Address:** \_\_\_\_\_

**Company Contact Phone Number:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**Employee SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**AFTER HOURS DRUG TEST**

Reasonable Suspicion    Post-Accident    Random    Return to Duty

**AFTER HOURS ALCOHOL TEST**

Breath    Blood    Saliva

**DOT Regulated employee**  Yes  No   **Fla Drug Free Workplace Company**  Yes  No

I, \_\_\_\_\_, am a designated representative from the company named above and hereby authorize the Occupational Health Service at University Community Hospital to provide testing of our employees as noted on this form. I understand that my company, not the employee, will be invoiced \$150.00 per employee for this service. Company agrees to pay all monthly invoices received for this service within 45 days of invoice date. Company also acknowledges that it is responsible for timely payment and will not send invoice on to its workers' compensation insurance company for payment to Occupational Health Service.

\_\_\_\_\_  
**Authorized Company Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**