



ON-THE-JOB-INJURY DRUG SCREEN AUTHORIZATION	Tfor022	Revision 5/12/10
Employee Information		
Rank: _____ Last Name: _____ First Name: _____		
Emp. #: _____		
Site Information		
Site Name: _____ Site Location: _____		
Testing Location		
Name Of Testing Facility: _____		
Street Address: _____		
City: _____		
State: _____ Zip Code: _____ Phone: 1-_____-_____		
Corporate Authorization		
Rank: _____ Last Name: _____ First Name: _____		
Position: _____ Date: _____ Time: _____		
How Authorization Was Received		
In Person: _____ By Phone: _____ By Fax: _____ By E-Mail: _____ Other: _____		
Employee's Acknowledgement		
I understand as a condition of my employment, if injured on-the-job, I will be required to submit to a drug screen at a facility so designated by Tracer, at no cost to myself.		
Rank: _____ Last Name: _____ First Name: _____		
Position: _____ Date: _____ Time: _____		
Signature: _____ Supervisor: _____		
Corporate Office Verification		
This form must reach the Corporate within 24 hours from date of drug screen.		
Date Received: _____ Signature: _____		