CHI Health

EMPLOYEE HEALTH

CONSENT TO TREATMENT

I, _____ (employee/patient), _____ (date of birth), understand that my employer/prospective employer has asked Employee Health (CHI Health) to perform the following procedures:

☐ **Non-Federal Drug/Alcohol Screen**

I have been fully informed that this urine/blood/hair/breath/saliva specimen will be analyzed for the presence of drugs/alcohol and CHI Health is not under any obligation to notify me of the results. **I also understand that CHI Health conducts adulterant screening on all stat drug screen collections and that the collection cups are equipped with temperature sensitive strips. If the specimen I provide shows signs of adulteration, or if the specimen I provide is not within the required temperature range, I may be subject to an observed drug screen according to my employer/prospective employer's directive. I understand that an observed drug screen means that an observer of the same sex will escort me into the restroom and stand in a position so that they are able to watch the urine come from my body into the collection container.** I hereby acknowledge that my employer/prospective employer has requested that CHI Health perform this testing. I understand that if I choose to leave without submitting an adequate specimen, my employer/prospective employer will be notified, and I will be subject to the actions outlined in their drug testing protocol. The screening results will become part of my permanent record and CHI Health will maintain a record of these results. I hereby authorize CHI Health to release any information obtained as a result of the drug/alcohol screen to be performed on me to my employer/prospective employer. This authorization covers only the drug/alcohol screen information completed by CHI Health for employer/prospective employer and does not include any other medical information which CHI Health may have in its possession as a result of my previously being a patient at CHI Health. I fully understand this and give my consent for this testing.

☐ **Physical Assessment - An evaluation to assess my physical condition and/or ability to perform certain functions.**

I hereby consent to the procedure(s) indicated on the authorization form. I further authorize the release of any results, reports, or summaries of the procedures(s) indicated that will be used to determine my fitness for employment for a specific position, or to meet state or federal regulations related to my employment. I understand that CHI Health is not under any obligation to notify me of the results of the procedures(s), and that the results will become part of my permanent records maintained by CHI Health. I understand that the procedure(s) indicated are limited to a work-related health evaluation and does not take the place of a full physical examination by my physician. I will hold harmless CHI Health, its affiliated companies and its employees, as well as my employer/prospective employer, their affiliated companies, subsidiaries, and employees from any and all liability as a result of this assessment.

I certify that the information provided to CHI Health is true to the best of my knowledge.

Employee / Patient	Date

The below named individual cannot read. The undersigned witness has read this document to the below named individual, answered any questions asked and witnessed the individual's signature.

Employee / Patient	
Witness Signature	Date

Photo ID Verified By Initials