Bulloch County
Pre-Employment Drug Testing
Consent and Release Form

I hereby consent to submit to urinalysis and/or other tests as shall be determined by Bulloch County in the selection process of applicants for employment for the purposes of determining the drug content thereof.

I hereby acknowledge that I have been notified of the requirements of the Bulloch County Drug Free Workplace Policy.

I hereby acknowledge that South Georgia Immediate Care Center may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by South Georgia Immediate Care Center for analysis.

I further agree to and hereby authorize the release of the results of said tests to Bulloch County Human Resources.

I understand that the current use of illegal drugs prohibits me from being considered for employment with Bulloch County.

I further agree to hold harmless Bulloch County and its agents (including the above named physician or clinic) from any liability arising in whole or in part, out of collection of specimens, testing, and use of the information from said testing in connection with Bulloch County consideration of my application for employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant (Print Name): _____ SSN: ___ - ___ - ___

Signature of Applicant: _____ Date: _____

Witness (Print Name): _____

Signature of Witness: _____ Date: _____

Signature of Guardian (if applicant/employee is under 18): _____ Date: _____

St. Joseph's/Candler URGENT CARE

SOUTH GEORGIA IMMEDIATE CARE CENTER

EMPLOYER'S AUTHORIZATION FOR EXAMINATION and/or TREATMENT

Employer must complete this form prior to the employee visit. **Employee** must present photo ID at time of service.

Employer Company Name: Bulloch County Board of Commissioners	
Patient Name	Patient SSN/ID#
Employer Physical Address: 115 N. Main Street, Statesboro, GA 30458	
Employer Billing Address: 115 N. Main Street, Statesboro, GA 30458	
Employer PRIMARY Contact Name: Thomas Capper	Employer PRIMARY Contact Title: Risk Management Technician
Employer PRIMARY Work Phone: (912)764-0100	Employer PRIMARY Mobile Phone
Employer PRIMARY Contact E-Mail: SafetyFirst@bullochcounty.net	Employer PRIMARY Contact Fax: (912)764-4609
Employer PRIMARY Contact Best contact: ☐ Work Phone ☐ Mobile Phone ■ E-mail ☐ Fax ☐ Other:	
Employer DER Name: Thomas Capper	Employer DER Best Contact: tcapper@bullochcounty.net
Authorization Signature	Visit Date

BILLING INFORMATION

■ Bill EMPLOYER (see Employer Billing Address above)

☐ EMPLOYEE to pay at time of Service

☐ Bill WORKERS' COMPENSATION Insurance Company / TPA*:

Ins. Co. _____

Policy # _____

Address _____

Phone _____

Contact _____

Claim # _____

WORK-RELATED INJURY CARE

Date of Injury: _____

☐ Evaluate and Treat ☐ Light Duty is Available

Be sure to indicate Drug Screen and/or Breath Alcohol Test required under *DRUG and ALCOHOL TESTING SERVICES*

Are Drug Screens and/or Breath Alcohol Tests covered by Workers' Comp Ins Co/TPA?

☐ Y ☐ N ☐ N/A

REPORTING RESULTS

☐ Fax paperwork to employer

■ E-mail paperwork to employer

☐ Call employer

☐ Give all paperwork to employee

☐ Give DOT card/Instant Screen Results Card only

SPECIAL INSTRUCTIONS

_____

_____

DRUG and ALCOHOL TESTING SERVICES

REASON FOR TESTING:

☐ Post-Accident ■ Random

■ Pre-employment ☐ Reasonable Suspicion

☐ DOT New Certification ☐ DOT Recertification

TEST REQUIRED:

☐ DOT Drug Screen ☐ Hair Follicle Testing

☐ 5-Panel Urine Screen ☐ Specimen Collection only

☐ Instant ☐ Breath Alcohol Test

☐ Lab-based

■ 10-Panel Urine Screen

■ Instant

☐ Lab-based

OCCUPATIONAL MEDICAL SERVICES

☐ DOT Physical – New Certification

☐ DOT Physical – Recertification

☐ Non-DOT Physical (Standard)

☐ Non-DOT Physical (Employer Provided)

☐ Fit For Duty Evalutaion (Physical + PPE)

Job Title/Desc _____

☐ Audiogram

☐ Pulmonary Function Test (PFT)

☐ Chest X-Ray

☐ Lumbar Spine X-Ray

☐ EKG

☐ TB Test

☐ Nicotine Test

☐ Flu Shot

☐ Hepatitis Vaccine (circle) ☐ A ☐ B ☐ Both

☐ Other _____