CITY OF FITCHBURG
Human Resources Department
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Fitchburg, WI 53711-5318
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www.city.fitchburg.wi.us

For Office Use Only

Date: _____ Time: _____

Location:
☐ GML ☐ Other: _____

Account:
☐ Non-Dot ☐ DOT

Authorization for Release of Information
Drug Free Workplace Program

It is the policy of the City of Fitchburg that its workplace be free from the illegal use, possession, or distribution of controlled substances by the employees of, or persons acting as agents of, the City. The City of Fitchburg requires all individuals it intends to hire to be drug-free. As a condition of employment, the City of Fitchburg requires applicants to successfully pass a pre-employment drug test. Refusal to submit to a pre-employment drug test, or an unjustified positive test result, will disqualify an applicant from employment with the City of Fitchburg and the applicant will not be offered employment with the city.

I, _____, do hereby authorize the City of Fitchburg and its duly appointed agent, to conduct testing and to obtain test results in connection with pre-employment drug testing. I authorize the City of Fitchburg's duly appointed agent to test for controlled substances which may include alcohol, Marijuana metabolites, Cocaine metabolites, Opiates metabolite, Morphine, Codeine, Phencyclidine, Amphetamines and Methamphetamine.

I further authorize the City of Fitchburg to obtain drug and alcohol test information from all previous employers within the preceding two years. I understand that any unjustified positive results will disqualify me from employment with the City of Fitchburg and I will not be offered employment with the city. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I understand that I am entitled to test results if I request such results within 60 days of being notified of an employment decision by the City of Fitchburg.

All testing will be performed by an independent, recognized medical facility, in accordance with the Department of Health and Human Services. Drug testing will be performed by a DHHS/SAMHSA certified laboratory utilizing clinically sound and approved testing methodologies. Specimens are initially screened for drugs using an immunoassay method. Any sample with a positive screening result will be confirmed using gas chromatography/mass spectrometry. Only samples testing positive by both methods will be reported positive to the Medical Review Officer (MRO). The name of the individual providing the specimen will remain confidential and will not be provided to the laboratory performing the test. The testing laboratory is only able to identify the specimen by the "specimen identification number" printed on the chain-of-custody form. Specimens testing positive will be frozen and retained for one year for additional testing.

Applicants will be given the opportunity to justify a positive test result when a confirmed positive result has been returned by the laboratory, the applicant will be interviewed by the medical staff of the collection facility, or their medical history will be reviewed to determine if a positive test result could have resulted from legally prescribed medication. If it is determined that there is no justification for the positive result, the medical staff shall contact the Human Resources Coordinator immediately.

Applicants will be notified by the Human Resources Coordinator of the time, date and location in which testing will occur. Transportation to and from the testing facility will be the responsibility of the applicant. A photocopy of this release form will be valid as an original thereof even though the said photocopy does not contain an original writing of my signature. This release form will be in effect for twelve months from the date of signing.

Applicant: _____
Please Print: First Middle Last

Address: _____
Street and Number City State Zip

Date of Birth: _____ Social Security Number: _____

Signature of Applicant: _____
Date

Signature of Witness: _____
Date