EMPLOYEE DRUG TESTING ADVISORY RECEIPT

I have received the document titled "Employee Drug Testing Advisory." I recognize that this is not a complete description of the drug-testing program, and that I am entitled to review the AD, Employee Drug Testing, which is available to me through the Unit Human Resources Manager, Central Human Resources Administrator, or the Central Drug Testing Coordinator

I understand that as an employee of the Arkansas Department of Correction, I am expected to support the concept of a Drug Free Workplace. I agree to submit to testing as required in the AD, Employee Drug Testing.

Should I be in a critical incident as described in the Administrative Directive, Employee Drug Testing, my signature below authorizes medical staff treating me to test for the presence of alcohol and other drugs, and to release the results of such tests to the Arkansas Department of Correction.

_____	_____	_____
PRINT YOUR NAME	POSITION	UNIT OR SERVICE
_____	_____	_____
SIGNATURE	DATE	SOCIAL SECURITY NUMBER

COPY: CENTRAL PERSONNEL FILE
UNIT OR SUPERVISOR'S FILE
EMPLOYEE (if requested)