

Left Dept. At:

# CITY OF BALTIMORE SUPERVISORY DRUG/ALCOHOL TESTING ORDER



All information **MUST** be provided. Employee must bring Photo Identification with the completed "Original – Medical Services" copy of this form.

The employee named below is scheduled to report for drug and alcohol testing at the City of Baltimore Occupational Medical Services (Mercy Clinic), 323 N. Calvert Street; (410-332-9773; Fax: 410-332-0614)

Employee Name:		Date of Request:     /     /	
Home Address:		SSN:	
City:	State:	Zip:	DOB:
Department:	Home Phone:		
Bureau:	Work Phone:		
Fund & Cost Center:	Division:		
	Occupation/ Job Title:		

### REASON FOR TESTING:

Non-Regulated	Regulated
Employee <b>MUST</b> be accompanied by Supervisor or Agency Designee:	
<input type="checkbox"/> Post Accident <input type="checkbox"/> Reasonable Suspicion <i>For Cause</i> (Requires SACO Signature)	<input type="checkbox"/> Post Accident (CDL) <input type="checkbox"/> Reasonable Suspicion <i>For Cause (CDL)</i> (Requires SACO Signature)
Supervision not required:	
<input type="checkbox"/> Probationary (CDL and Non-CDL applies)  <input type="checkbox"/> Supervisory Monitoring <i>Performance Improvement Plan</i> (CDL and Non-CDL applies)  <input type="checkbox"/> Return to Duty (Non-CDL)	<input type="checkbox"/> Follow-up (CDL) <i>SAP ordered</i>  <input type="checkbox"/> Return to Duty (CDL) <i>Return to driving</i>

Department Head's Name: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Supervisor's Work Title: \_\_\_\_\_

Supervisor's **Signature**: \_\_\_\_\_

Substance Abuse Control Officer's **Signature**: \_\_\_\_\_

Substance Abuse Control Officer's Work Phone: \_\_\_\_\_

**In ALL CASES of positive Drug/Alcohol Test results, the department's Designated Human Resources Authority, EAP, and the Safety Division will be notified.**

Supervisor retains last copy and distributes as directed below.

- 1) Original – Medical Services
- 2) Designated HR Authority
- 3) Supervisor