Consent for Release of Drug & Alcohol Test Results/Treatment Records/Refusals to Test History

INSTRUCTIONS: Please complete all information as requested. Releases submitted without complete information or the SSN# will not be processed. Please make copies for future use!!!

FAX or MAIL this form to:

Michelle M. Dearlove, CPA
Educational Services District 123
3918 W. Court Street
Pasco, Washington 99301
Fax (509) 544-5795

Applicant Name:_____ SSN#_____
(Last) (First) (MI)

Address:_____

City/State/Zip Code:_____

APPLICANT: COMPLETE ONE FORM FOR EACH PREVIOUS EMPLOYER FOR THE LAST THREE (3) YEARS. MAKE SURE TO INCLUDE COMPLETE ADDRESS NUMBER, CITY, STATE AND ZIP CODE.

Previous Employer:_____Dates:_____to:_____
(Legal Business Name)

Street Address:_____

City/State/Zip Code:_____

I authorize the previous employers listed above to disclose to ESD #123 the results of any drug test, evidential alcohol breath test, refusals to test, and treatment records (to determine compliance with Section 382.605 FMCSR), performed upon myself within the last three (3) years as required under Federal Requirement 49 CFR Part 40 Subpart 382.413. I further agree to allow ESD #123 to disclose this information to my prospective employer listed below, and agree to hold harmless any previous employers as listed, ESD #123, its Directors, employees, agents or volunteers for any damages, loss of employment, or any negative outcome that may result from such disclosure. This consent is subject to revocation at any time. However, such revocation does not apply to disclosures made prior to notice. I understand I have the right to inspect and copy any written information disclosed.

Signature of Applicant:_____ Date:_____

Prospective Employer:_____ Phone:_____

City/State/Zip Code:_____

Signature of Employer Representative:_____