**Hair Follicle Drug Test Authorization**

|  |
| --- |
| **Employee Name:**  |
| **Employee’s Supervisor:**  |
| **I do agree to allow my hair to be used for drug testing purposes. If the test does come back negative for the alleged substance, I will be able to continue my employment and be compensated for any missed time because of the testing.****I do realize that if the drug test does come back positive for the alleged substance, I will be responsible for the cost of the drug test which will be deducted from my last check. My employment will then be terminated.** |
| **Location:**  |
|  |
| **Employee’s comments:** |

***EMPLOYEE'S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |  |
| --- | --- |
| **Supervisor’s Name:**  | **Date:**  |
| **Supervisor's Signature:** |