CFD FORM 6.19

OHS
OCCUPATIONAL HEALTH SERVICE
2005 Bay Street, Taunton, MA 02780 508-824-0243 Date:_____

Testing Notification

Client Company Name:

Dear_____:

You must report for a **Drug** Test and/or a Breath **Alcohol** Test for:

** ( ) Post Injury/Accident ( ) Reasonable Cause/Suspicion ( )Random

**The designated employer representative requesting the test should have discussed the reason for the test with you.

Your test has been scheduled for: _____(day)

_____(date)

_____AM/PM.

Or you can call the below number to schedule your test within _____hours.

Please report to: Occupational Health Service (OHS) or an Employer Designated Site:
Northwoods Medical Center
2005 Bay Street _____
Taunton, MA 02780
(508) 824-0243 ext 301 or 302 _____

Please follow these guidelines:

1. Be sure to have a **PICTURE ID** with you when you report for testing.
2. Be prepared to give the specimen required when you arrive.
3. Courtesy to the testing staff is MANDATORY, rude or inappropriate behavior will constitute a refusal to test.
4. Please bring the Client Request for Services form with you when you come.
5. Also bring this form (Testing Notification) with you and give the forms to the receptionist and/or collector. This form can be returned to you as evidence of having reported for testing.

Thank you for your cooperation.

DO NOT WRITE BELOW THIS LINE: TESTING STAFF ONLY:

Date Test Completed:_____

Collector's Signature:_____

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