FLORIDA ORTHOPAEDIC INSTITUTE
SUMMARY OF THE EMPLOYEE SUBSTANCE ABUSE POLICY
AND CONSENT TO BE TESTED

❑ As a condition of employment I will be required to submit to these types of drug and/or alcohol tests: job applicant; reasonable suspicion (cause), routine fitness for duty (if used), return to duty, follow up, and post accident.

❑ If I refuse to submit to the testing or have a positive drug or alcohol test result:
(1) as a job applicant - my offer of employment which was conditioned upon successfully passing a drug test will be terminated;
(2) as an employee - the Company will take disciplinary action up to and including discharge from employment and I may forfeit my worker's compensation medical and indemnity benefits.

❑ I can confidentially report the use of prescription and non-prescription medications before and after being tested. A list of medications which affect the testing is available. A list of all drugs that the Company will test for is posted and is in an appendix to the Substance Abuse Policy and is posted. Names, addresses, telephone numbers of employee assistance and rehabilitation programs are available for my use.

❑ I may consult with the Medical Review Officer as to my drug test results. I may explain or contest within 5 days after a written notice of a positive test result. I must notify the laboratory if I wish to start civil or administrative action. All drug program reports, results, and information are confidential and not released without my authorization.

❑ My rights and responsibilities are covered under State law/s, including but not limited to Florida Statute 440 - Workers' Compensation, Drug Free Workplace Program. The complete Substance Abuse Policy and procedures are available for my review during normal business hours and portions of them are also posted in work locations.

I HAVE READ AND UNDERSTAND THE ABOVE SUMMARY OF THE COMPANY'S SUBSTANCE ABUSE POLICY AND FREELY CONSENT TO BE TESTED FOR DRUGS AND ALCOHOL, AND AUTHORIZE THE COLLECTION AND TESTING OF MY SPECIMEN. I ALSO AUTHORIZE THE SPECIMEN COLLECTION PERSONNEL, THE LABORATORY, AND THE MEDICAL REVIEW OFFICER TO PROVIDE THE TEST RESULTS, MEDICAL RECORDS, WRITTEN REPORTS, AND DATA CONCERNING MY TESTS TO THE APPROPRIATE COMPANY REPRESENTATIVE AND RELEASE THEM FROM ANY LIABILITY ARISING FROM DOING SO.

_____	_____
Employee/Applicant Printed Name	Employee/Applicant Signature
_____	_____
Social Security No.	Date

REFUSAL TO TEST

I hereby refuse to submit to the required testing and acknowledge the consequences of my refusal, as described above.

_____	_____
Employee/Applicant Printed Name	Employee/Applicant Signature
_____	_____
Social Security No.	Date