Mo-Kan Construction Industry Substance Abuse Fund (CISAP)
CONSENT/AUTHORIZATION FORM

NAME_____
(Last) (First) (Middle Initial)

ADDRESS_____
(No.) (Street) (City) (State) (Zip)

SSN_____ TELEPHONE (HOME/CELL) _____/_____ BIRTHDATE_____

SEX_____ TRADE UNION_____ UNION ID_____

EMPLOYER _____ PHONE_____

ADDRESS_____
(Street) (City) (State) (Zip)

Consent for Drug Testing by CISAP

I hereby give consent for the personnel of the Mo-Kan Construction Industry Substance Abuse Fund (CISAP), its designated Program Administrator, laboratory and any clinic contracted with to take samples of my blood and/or breath, and/or urine to test for drugs and alcohol in my body. I request this drug and/or alcohol testing voluntarily, and with no promises from anyone about what the results will be. I understand that the test(s) may disclose information that is unfavorable to me or may interfere with my current or future employment. I hereby authorize the use or disclosure of protected health information about me as described below.

Authorization to Release Results from Program Administrator

The CISAP Program Administrator is authorized to release the results of the drug and/or alcohol test(s) regarding the sample collected today to the Mo-Kan Construction Industry Substance Abuse Fund (CISAP), its agents, attorneys, administrators, service providers, and to any union and/or employer participating in CISAP, and to any Training Trust Fund to which I am a participant. The information may be used or disclosed for determining my exposure to controlled substances. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the federal privacy regulations.

I understand and agree that if I refuse to provide a urine specimen or if I leave a collection site before I provide a urine specimen, that such action will be treated as a positive test by CISAP, that my Employer will be immediately notified and that I will be subject to discipline by my Employer up to and including termination.

I understand that I may revoke this authorization by notifying CISAP or its Program Administrator in writing at the address below of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by CISAP, its agents, attorneys, administrators, service providers, or any union, Training Trust Fund and/or employer participating in the program provided by CISAP in reliance on it before I revoked it.

I understand that CISAP, Program Administrator, or its agents may not condition treatment of me on whether or not I sign this authorization. I understand that refusal to sign this authorization may have an adverse effect on my current or future employment which may, in turn, affect my eligibility for employment benefits. I understand this authorization will expire 5 years from the date of execution of this document.

CISAP
Attn: CISAP Program Administrator
6405 Metcalf Avenue, Suite #212, Overland Park, KS 66202 - (913) 312-5405 - Fax (913-312-5406

Date_____ Signature_____

Picture ID_____ Verification_____

This test is for:

_____ pre-employment	_____ post incident	
_____ return to work	_____ Random	_____ reasonable suspicion
_____ follow-up	_____ Other	_____ initial