DRUG TEST RESULT
APPEAL FORM

The purpose of this form is to provide the employee an opportunity to contest the drug test result findings as reported by Medical Review Officer (MRO) within ten (10) business days upon receipt of being informed by the respective appointing authority. Please indicate your intention and initial either "Yes" or "NO".

Failure to submit the Drug Test Result Appeal form, within the ten (10) business days to the Department of Administration, shall result as an "Acceptance" of the drug test result.

_____ ***YES***, I am exercising my right to dispute the drug test findings as reported by the Medical Review Officer (MRO). I understand that I may "retest" the same urine sample and the cost of the "retest" will be at my own expense. Also, I am aware that a payment of $150.00, must be received by the Department of Administration during this period before a ***"re-test"*** of the same urine specimen is authorized. In addition, I may provide additional supporting documents to be considered within the time period even if I do not request a ***"re-test"*** of the same urine specimen to be performed.

_____ **NO**

PART A: (*To be completed by the Employee)*

I acknowledge receipt of this form and have read and understood its contents. I voluntarily and willingly admit to the foregoing without pressure, intimidation or harassment on the part of management in entering this appeal. Submission of the Drug Test Appeal Form must be received by the Department of Administration within ten (10) business days from the date of receipt of your memo from your appointing authority informing you of your drug test results. Failure to submit the Drug Test Result Appeal form, within the ten (10) business days, shall result as an "Acceptance" of the drug test result.

_____ _____

Employee Signature Print Name

XXX-XX-_____ _____

Last 4 Digits of SSN # Date

PART B: (*To be completed by the Department of Administration – Drug-Free Workplace Coordinator / EAP Administrator)*

	YES	NO
1) Did employee attach supporting documents?	☐	☐
2) Did employee attach supporting documents from physician?	☐	☐
3) DOA submitted documents and/or notified the MRO and/or laboratory?	☐	☐

_____ Signature of DOA DFWP Coordinator / EAP Administrator	DFWP – EAP STAMP RECEIVED:

********** NOTHING AS FOLLOWS **********