DRUG TEST RECORDS REQUEST FORM

The purpose of this form is for an applicant or employee to formally request access and be provided copies of documents pertaining to their Drug Testing or Treatment / Rehabilitation records. As an applicant or an employee of the Government of Guam, I request to access records relative to my drug screening test and/or drug/alcohol treatment and rehabilitation. I understand that copies of my records will be released by the Department of Administration to me or my authorized representative. By requesting such, I hereby release the Department of Administration and its employees from any and all liabilities regarding the confidentiality of these records. Please be advised records may be released by DOA if legally ordered.

PART A: APPLICANT/EMPLOYEE INFORMATION (*To be completed by the requesting applicant/employee)*

By signing below, I acknowledge receipt of this form and have read, understood and agree with its contents.

Date: _____ **Email Address:** _____

Release my Records (Select one option only): ☐ Electronic mail: ☐ Pick-up:

Applicant/Employee Name: _____ **Social Security No**.: XXX-XX _____

Position Title: _____ **Employee ID**: _____

Department: _____ **Section:** _____

Records Requested: _____ **Purpose of Request:** _____

Applicant/Employee Signature: _____ **Ph. No:** _____

PART B: AUTHORIZATION RELEASE (*To be completed if the employee authorizes a representative to obtain copies, please attach copy of Applicant/Employee and Representative valid picture identification)*

I, the above-mentioned employee hereby acknowledge and authorize the following representative to obtain copies of my drug testing records. This authorization is valid for 10 business days from the date of the Employee's Signature below.

Representative's Name: _____ **Representative's Signature:** _____

Applicant/Employee Signature: _____ **Date**: _____

PART C: DEPT OF ADMIN. (*To be completed by Drug Program Specialist/EAP Coordinator if Part B is completed)*

QUESTIONS	YES	NO
1) Applicant/Employee's valid picture ID attached? If no, do not provide records		
2) Authorized representative's valid picture ID attached? If no, do not provide records		

_____ Signature of DOA Drug Program Specialist / EAP Coordinator	EAP STAMP RECEIVED:

Copy of Records were provided to: ___Employee ___Representative, on (date): _____, via: ___Email ___Pick-up