



**AUTHORIZATION & AGREEMENT
FORM**

3040 N. Hemlock Circle
Broken Arrow, OK 74012

918-258-1111
1-800-316-2222
FAX: 1-918-806-0253

REFERENCE AUTHORIZATION:

I authorize Oxford HealthCare and/or its agents, including consumer-reporting bureaus, to verify my employment experience. I also authorize any reference source to provide Oxford HealthCare with any and all information covering my background and hereby release any said sources from any liability for any damage whatsoever for issuing this information. A copy of this document shall have the same force and effect as the original.

LAST NAME

FIRST NAME

MIDDLE NAME

SOCIAL SECURITY #/IDENTIFICATION

POSITION APPLIED FOR

FORMER NAMES

SIGNATURE OF APPLICANT

DATE

RELEASE OF INFORMATION

I agree that if the company or its employees are subject to review or investigation for accreditation or law enforcement purposes or to remain a participant in federal health care programs, I will cooperate in such investigations, which may include the release of information related to my employment with the company.

SIGNATURE OF APPLICANT

DATE

AT WILL EMPLOYMENT

I understand and agree that any employment offered to me will not be for any definite period of time and is subject to termination with or without cause by the company or myself at any time. I further understand and agree that my employment will be "at will," that no statements have been made to the contrary and that this policy cannot be changed except in writing, signed by an authorized officer of the company.

SIGNATURE OF APPLICANT

DATE

AUTHORIZATION AND CONSENT FOR DRUG AND ALCOHOL SCREEN

I give full permission and authorization to have Oxford HealthCare and/or its agent send a specimen of my urine and/or blood to a laboratory for screening using N.I.D.A. standards for the presence of illegal drugs, alcohol, or prescription medication taken without a prescription.

I will hold all parties involved harmless, meaning I will not send or hold them responsible for any alleged harm to me or interfering with my obtaining a job or continuing employment as a result of not submitting to the tests or as a result of the determination of the testing. This includes, but is not limited to any possible clerical or laboratory errors made.

I understand that this is a legally binding document, which is binding because Oxford HealthCare is both sending me for the examination and paying for the examination. I fully understand the wording of this document.

Should an accident occur while on assignment, I understand that a drug or alcohol screen will be required immediately. Additionally, I understand that when my employer has a valid suspicion of my drug use and a further belief that my poor performance is directly related to such drug use, then I may be subject to a drug test. My refusal to submit to the drug or alcohol testing under the terms and conditions outlined hereinabove will be grounds for immediate termination.

Any positive drug test result may result in my immediate termination.

I _____ (employee name), hereby understand that as a condition of my employment, I may be subject to drug/alcohol testing for the following reasons:

Pre-employment

For Cause/Suspicion

Post-Hire

Post-Accident

My signature below indicates my acknowledgement that, should a drug/alcohol test be requested or be appropriate under the above drug/alcohol screen authorization and consent, and if I fail a test or refuse to submit the required blood or urine sample for the authorized screen, such failure or refusal, for whatever reason, will be grounds for termination.

Employee Signature: _____ **Date:** _____