Pre-Employment Drug Screening

Acknowledgement Statement

I, _____, acknowledge that I have read and understand the following stipulations required by State law:

1. I understand that, as a condition of employment with Advantage Behavioral Health Systems (Advantage), I must take and pass a drug test. The test is conducted under the authority of O.C.G.A. 45-20-110 to determine the presence of illegal drugs.

2. I understand that this condition of employment applies to me if I am not employed by any State employer on the day prior to the start date of the position for which I am applying (e.g. I would be a new State employee or have at least one day break in service.).

3. I am willing to take the drug test as directed, and I understand that the cost of this drug test will be paid by the employer.

4. I understand that, if I refuse to take the drug test or fail to appear at the testing location by the specified date, I will be disqualified from employment with any State employer for a period of two years.

5. I understand that, should my drug test results indicate the presence of illegal drugs and such presence is not found by the Medical Review Officer to be authorized by state or federal law, I will be disqualified from any employment with any State employer for a period of two (2) years from the date that the test was administered.

6. I acknowledge that I have taken or have been asked to take a drug test for the following State employers within the last two years (includes any agency, department, commission, bureau, board, college, university, institution, or authority):

State employer	*Date of test*
_____	_____
_____	_____
_____	_____

7. I certify that the results for each test showed no presence of illegal drugs.

8. I acknowledge that withholding or falsifying any of the requested information will result in immediate termination of my employment with Advantage Behavioral Health Systems (Advantage).

I understand that, if I refuse to sign this form, I am forfeiting any further consideration for this position with Advantage Behavioral Health Systems (Advantage).

_____ Printed Applicant's Name

_____ Applicant's Signature

_____ Social Security Number

_____ Date

_____ Signature of Witness