DESIGNEE FOR REPORTING RESULTS
AUTHORIZATION REQUEST FORM

Drug Screening Program (designated positions)

Name	Title	Employee ID#	Work Phone	E-mail address	FAX Number

Alcohol and Controlled Substance Testing Program for Commercial Drivers

Name	Title	Employee ID#	Work Phone	E-mail address	FAX Number

Please place an 'x' by the primary designee for your agency.

Agency Name: _____ Agency Number: _____

Completed By: _____ Date Completed: _____ Phone: _____

Please submit to: **Drug Screening Program Records Coordinator**
Department of Administration, Office of Personnel Services
900 SW Jackson, Room 401-N
Topeka, Kansas 66612