DESIGNEE FOR REPORTING RESULTS
AUTHORIZATION REQUEST FORM

Drug Screening Program (designated positions)

Name	Title	Work Phone

Alcohol and Controlled Substance Testing Program for Commercial Drivers

Name	Title	Work Phone

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

Agency Name: _____ Agency Number: _____

Date Completed: _____ Completed By: _____ Phone: _____

Please submit to: **Sharon Swoyer, Drug Screening Program Records Coordinator**
Department of Administration, Division of Personnel Services
900 SW Jackson, Room 252-S
Topeka, Kansas 66612

DPS 415