DESIGNEE FOR REPORTING RESULTS
AUTHORIZATION REQUEST FORM

Drug Screening Program (designated positions)

Name	Title	Work Phone	E-mail address

Alcohol and Controlled Substance Testing Program for Commercial Drivers

Name	Title	Work Phone	E-mail address

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