

Truck Driver Training

Pre-Employment DOT Drug Screen (Five Panel)

Prospective Student

Date and location of the class you are applying for _____

Full Name (Print) _____

Social Security Number _____

Mailing Address _____

City/State/Zip _____

I, _____, hereby give my full authorization and consent to the medical facility listed below to release my drug testing results to Caldwell Community College and Technical Institute/Truck Driver Training. I understand that this drug screen is a pre-registration requirement, regardless of the outcome of the drug test. I also agree not to hold the medical testing facility or CCC& TI and their officers, directors, employees, and/or agents liable in any action pursuant to the outcome of this drug testing.

Signature _____ Date _____

Witness Signature _____ Date _____

For Physician's Use Only

From the office of: _____

***Mail, fax or email Drug Test Results to:** Designated Employer Representative (DER)
Roger Chester, Director, Truck Driver Training
Chris Thompson, Program Technician, Truck Driver Training
Caldwell Community College
2855 Hickory Boulevard
Hudson, NC 28638
Phone (828) 726-2386
Secure Fax (828)726-6302
Email cthompson@cccti.edu or rchester@cccti.edu



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