REFERENCES REQUEST

Please provide references

(2) Business

1). ______________________________

Business Name

____

Contact Person

____

Address

____

Phone Number

2). ______________________________

Business Name

____

Contact Person

____

Address

____

Phone Number

(1) Personal

1). ______________________________

Business Name

____

Contact Person

____

Address

229-426-5205

Phone Number

I hereby authorize Ben Hill MR Service d/b/a The Jessamine Place to check the references listed above and those on my application in regard to employment suitability.

______________________________ ______________

Applicant **Date**

PRE-EMPLOYMENT DRUG SCREENING
ACKNOWLEDGEMENT STATEMENT

I, ____ , acknowledge that I have read and understand the
(Name of Applicant)
following stipulations required by State Law:

1. As a condition of employment I must take **and satisfactorily pass** a drug screening test **prior to the effective date of employment** with the Georgia Department of Human Resources. The Test is conducted to determine the use of illegal drugs.

2. I am willing to take the drug screening test at one of the locations specified by the Georgia Department of Human Resources.

3. I understand that if I refuse to take the drug screening test, of fail to appear at the specified testing location by the imposed deadline, I will be disqualified from employment with any State agency, department, commission, board or authority (including public school systems) for a period of two (2) years.

4. I have taken the drug screening test for the following State agencies, department, commissions, boards or authorities within the last two (2) years (including, public school systems):

Agency/Authority	**Date of Test**
________________________________	____________________
________________________________	____________________

5. I certify that I did not test positive for the use of illegal drugs for the above-listed State agencies, departments, commissions, boards or authorities (including public school systems).

6. I acknowledge that withholding of falsifying of any of the requested information will result in immediate termination of employment with the Georgia Department of Human Resources.

7. I understand that should my drug screening test results indicate the use of illegal drug and such use is not found by the Medical Review Officer to be authorized by State of Federal law, I will be disqualified from any employment with any State employer (including public school systems) for a period of two (2) years from the date of the test was administered.

I understand that if I refuse to sign this form I am withdrawing myself from any further consideration of employment with the Georgia Department of Human Resources for this position.

________________________________	________________________________
(Print Applicant Name)	**(Applicant Signature)**
________________________________	________________________________
(Social Security Number)	**(Date)**