

**UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
HARRINGTON MEMORIAL HOSPITAL
CONSENT TO DRUG TESTING**

I, _____ (print name), am a student at the University of Massachusetts Medical School (“UMMS”) and would like to participate in a voluntary clinical rotation at Harrington Memorial Hospital. I have been advised that as part of this proposed clinical rotation, Harrington Memorial Hospital requires all participants to be subject to drug testing. Through this signed document, I hereby give my voluntary and unqualified permission, authorization, and consent to allow and permit Harrington Memorial Hospital to administer and interpret a drug screening test as a condition of my participation in this clinical rotation. I also understand, acknowledge and agree I will be personally responsible for paying the cost of the drug screening test.

I further understand, acknowledge and agree that based on my drug screening results, Harrington Memorial Hospital may elect not to permit me to participate in the clinical rotation. I also authorize, permit and consent to allow Harrington Memorial Hospital to provide the results of the drug screening test to UMMS, which may then determine if any further disciplinary action against me is necessary or appropriate.

I CERTIFY AND AGREE I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE TERMS AND CONTENT OF THIS “CONSENT TO DRUG TESTING.” I AM OF LEGAL AGE, COMPETENT, UNDER NO DURESS, AND AM SIGNING THIS DOCUMENT OF MY OWN FREE ACT AND WILL.

Signed: _____

Date: _____

Witness Signature

Print Witnesses Name