HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

Exhibit 2.1.4
09/2007

DRUG SCREENING AUTHORIZATION FORM

Name _____

I understand that Hawaii Health Systems Corporation (HHSC) has established a policy, whereby any person who has received a conditional offer of employment, or is seeking to provide services to HHSC or wants to be considered for clinical instruction, will be tested for the presence of drugs.

1. I agree to present myself at the appointed time at the testing laboratory designated by HHSC and identify myself with a valid picture identification (i.e., Hawaii Driver's License, State Identification Card, Passport or Military Identification Card).
2. I understand that if I fail to report to the test site at my appointed time, this will be deemed as a "refusal to test", and the respective Human Resources Office may rescind any conditional offer of employment or may disapprove the request for vendor services or may not consider me for clinical instruction.
3. I authorize the testing laboratory to take from me the required specimen for testing.
4. I understand that the specimen will be tested to determine the presence of drugs, using a chain of custody procedure to ensure the integrity of the specimen and its identification.
5. I understand that my specimen will be tested for the following drugs: marijuana, cocaine, opiates, amphetamines (including crystal methamphetamine), phencyclidine (PCP), barbiturates, propoxyphene, methaqualone, benzodiazephines, and methadone.
6. I understand that over-the-counter medications or prescribed drugs may result in a positive test result and that I will have an opportunity to discuss my medications/drugs with the Medical Review Officer (MRO) if my specimen tests positive.
7. I understand that a copy of the results of this testing will be forwarded to the respective Human Resources Office of the applicable facility for review and that the facility may rescind any conditional offer of employment, or may disapprove the request for vendor services or may not consider the student/teacher for clinical instruction if the results indicate the presence of any illegal, dangerous or unauthorized drugs in my system.
8. I understand that if I do not agree with the results of the drug test, I may request a re-test (using the same sample) by contacting the Medical Review Officer (MRO) within three (3) working days of being notified of the test results.
9. I understand that if I am accepted for employment, to provide services or for clinical instruction with HHSC, I will abide by the HHSC Alcohol Free and Drug Free Working Environment Policy.
10. In addition, I agree to release to HHSC and its affiliates, agents and employees from any and all liability or responsibility related to the administration of testing, testing procedures, or any act or omissions arising there from or related thereto.

_____ _____
Signature (Participating Student) Date

_____ _____ _____
Print Name (Parent/Legal Guardian) Signature (Parent/Legal Guardian) Date

***Please return completed form to Human Resources.**