SAN JOAQUIN COUNTY- SUPERVISOR REFFERAL

FOR NON- DOT- REASONABLE SUSPICION- DRUG/ ALCOHOL TESTING

To: Healthcare Facility: _____

Employee/ Job Title: _____

Name: _____

Employee ID Number: _____ Date of Birth: _____

Department/ Division: _____

Date of Referral: _____ Time: _____AM/PM

The supervisor is to present this form to: (check one of the boxes)

☐ **Co Occupational Medical Partners**

1530 East Hammer Lane
Stockton, CA 95210
Telephone: 209-954-3200
Fax: 209-954-3250
Hours: Monday through Friday: 8:00 AM to 5:00 PM

AFTER 5:30 PM AND ON WEEKENDS TAKE EMPLOYEE TO:

☐ **St. Joseph's Medical Center- HealthCare Clinical Laboratory within the hospital**
1800 North California St- 1st Floor adjacent to the Lobby, Stockton, CA 95204
Telephone: 209-467-6330 – (this facility can administer a breathalyzer test)

Name of Referring Supervisor: _____
Print Sign Date

Telephone Number: _____

NOTE TO HEALTHCARE FACILITY

RESULTS OF THIS DRUG/ALCOHOL TEST ARE TO BE SENT TO:

SAN JOAQUIN COUNTY RISK MANAGEMENT

sjcriskmgmt@sjgov.org and ebell@sjgov.org

or

Fax 209-953-7330