

**TO:** \_\_\_\_\_  
(List Medical Provider)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FROM:** \_\_\_\_\_  
(List Your Business)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SUBJECT:** Drug Testing of Injured Worker(s)

It is the policy of \_\_\_\_\_ to  
(Business Name Here)  
provide a safe work environment for all of our employees. Accordingly, any employee of  
\_\_\_\_\_ who receives medical treatment for an  
(Business Name Here)  
on-the-job accident is to be drug tested. This is to serve as your official notification to  
conduct the drug test with no exceptions. In the event the injured worker refuses the  
drug test, we request you document his/her refusal.

Signed: \_\_\_\_\_  
(Company Representative)