UC-843(Rev 7/17/15)

CONNECTICUT DEPARTMENT OF LABOR
Drug and Alcohol Testing Questionnaire

Case #:

CLAIMANT NAME: **SSN #:**

Dear Employer:
The above named individual has indicated that his/her unemployment resulted from the failure of a drug/alcohol test. Certain information regarding the test is required in order to determine the individual's eligibility for unemployment benefits and the extent of your account's liability for any benefits which may be paid. The following release authorizes you to disclose the information requested below for the purpose of determining the claimant's eligibility for unemployment benefits.

EMPLOYER NAME: ***EMPLOYER REG #:***

I *hereby authorize the above named employer to release to the Department of Labor the information requested below and any clarifying information that may be required for the purpose of determining my eligibility for unemployment benefits.*

CLAIMANT'S SIGNATURE:_____ DATE:_____

1. When was the drug/alcohol test administered? _____
2. What type of test was administered? (e.g., urinalysis test; breath alcohol test) _____
3. What was the nature of the test? (e.g., reasonable suspicion; pre-employment; random) _____
4. Explain in detail why the individual was referred for the test (e.g., in the case of "reasonable suspicion" testing, what kind of behavior was observed and by whom? _____
5. Was the test mandated by federal law? Yes ☐ No ☐ Please explain:
6. Was the claimant legally disqualified under state or federal law from performing the job for which s/he was hired as a result of the failure of the test? Yes ☐ No ☐ Please explain:
7. Please attach:
   - ☐ a copy of the Federal Drug Testing Custody and Control Form, if applicable
   - ☐ a copy of the Medical Review Officer's certification of the test result, if applicable
   - ☐ a copy of the Breath Alcohol Testing Form with test results affixed, if applicable
   - ☐ in all cases, a copy of the applicable portion of the employer's drug/alcohol testing policy
8. Rebuttal to information provided by the claimant is requested. Yes, copy attached ☐ N/A ☐

Please be advised that if your response to this questionnaire is not received
By **on**
a decision will be issued based on the information available.

_____	_____	_____	_____
EMPLOYER REPRESENTATIVE	*TITLE*	*PHONE*	*DATE*

RETURN THIS COMPLETED QUESTIONNAIRE AND ANY ADDITIONAL INFORMATION TO:

ADJUDICATIONS SPECIALIST: PHONE #: FAX #: