STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center • Bland Bryant Building
55 Wade Avenue • Baltimore, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

2010 – 2012 Registration Cycle

Attention: EDT Registration Renewal

Dear Employer,

Enclosed you will find an application to renew your registration for your business to conduct screening tests for drugs of abuse as required by Health-General Article §17-205(d)(2). Renewing your registration allows you and/or your agent to perform drug screening tests on job applicants using single use drug testing kits.

Please complete the form and return it with a $50 registration fee. Once processed, you will receive a registration letter effective for two years. Mail completed registration to:

Laboratory Licensing – EDT Registration
Office of Health Care Quality
Spring Grove Center-Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228

A person who violates the registration requirement or any or provision of the Maryland Annotated Code regarding specimen testing may be subject to a criminal conviction and fine. (Maryland Annotated Code Health-General §17-605)

If you are no longer performing drug screening test on job applicants using single use drug testing kits, please notify our office in writing. If you have any questions regarding this process, please contact Cheryl Sloan at 410-402-8025.

Sincerely,

Renee B. Webster
Assistant Director, OHCQ

STATE OF MARYLAND

DHMH - RENEWAL

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality – Laboratory Licensing Programs
Spring Grove Center – Bland Bryant Building, 1st Floor
Catonsville, Maryland 21228
Voice: 410-402-8025 Facsimile: 410-402-8213

Office Use Only:
Registration # **EDT -** _____
Check # _____ Amt $_____
Date Rec'd: _____

Employer Point-of-Collection/ On-Site Drug Testing Registration Form

BUSINESS/EMPLOYER NAME:		
ADDRESS:	TESTING SITE: **YES** _____ **NO** _____	
CITY/STATE/ZIP CODE:		
CONTACT PERSON NAME /POSITION:	TELEPHONE NUMBER:	FAX NUMBER:
TESTING AGENT (IF NOT EMPLOYER):	TELEPHONE NUMBER:	FAX NUMBER:
TESTING AGENT ADDRESS:	TESTING SITE: **YES** _____ **NO** _____	
CITY/STATE/ZIP CODE:	HOURS OF OPERATION:	
TESTING PERSON NAME(S):		
TESTING SITE LOCATION(S) (IF NOT INDICATED ABOVE):		
NAME AND ADDRESS OF LAB USED FOR NON-NEGATIVE CONFIRMATION:	TELEPHONE NUMBER:	
	FAX NUMBER:	
NAME OF TEST KIT(S) USED AND MANUFACTURER(S):		
EMPLOYER SIGNATURE:	TITLE:	DATE: