

FOR CAUSE DRUG/ALCOHOL TESTING CHECK LIST

Employee Name: _____

Dept: _____

Were there Drugs or Alcohol on the Employee's person or in the vicinity? Yes No

If yes, describe in narrative section

Was there a Report of Drug/Alcohol Use by the Employee while at work/on Duty?

If yes, describe in narrative section

Yes No

Was there information that the employee tampered with a drug/alcohol test?

If yes, describe in narrative section

Yes No

Are there excessive or unexplained absenteeism or tardiness?

If yes, describe in narrative section

Yes No

Conduct Suggesting Impairment or Influence of Drugs/Alcohol

Check all that apply

Yes No

WALKING

- | | | | | |
|---|-------------------------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Falling | <input type="checkbox"/> Holding on | <input type="checkbox"/> Staggering | <input type="checkbox"/> Swaying | <input type="checkbox"/> Unsteady |
| <input type="checkbox"/> Unable to walk | <input type="checkbox"/> Swaying | | | <input type="checkbox"/> Normal |

STANDING

- | | | | | |
|--|-------------------------------------|----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Feet wide apart | <input type="checkbox"/> Rigid | <input type="checkbox"/> Swaying | <input type="checkbox"/> Sagging at Knees | |
| <input type="checkbox"/> Unable to Stand | <input type="checkbox"/> Staggering | | | <input type="checkbox"/> Normal |

SPEECH

- | | | | | |
|----------------------------------|-------------------------------------|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Silent | <input type="checkbox"/> Incoherent | <input type="checkbox"/> Rambling | <input type="checkbox"/> Shouting | <input type="checkbox"/> Slow |
| <input type="checkbox"/> Slurred | <input type="checkbox"/> Whispering | | | <input type="checkbox"/> Normal |

DEMEANOR

- | | | | | |
|------------------------------------|--------------------------------------|----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Calm | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Crying | <input type="checkbox"/> Fighting | <input type="checkbox"/> Polite |
| <input type="checkbox"/> Sarcastic | <input type="checkbox"/> Talkative | <input type="checkbox"/> Excited | <input type="checkbox"/> Sleepy | <input type="checkbox"/> Normal |

ACTIONS

- | | | | | |
|---|----------------------------------|--------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Calm | <input type="checkbox"/> Drowsy | <input type="checkbox"/> Erratic | <input type="checkbox"/> Hostile | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Profane | <input type="checkbox"/> Threatening | <input type="checkbox"/> Excited | |
| <input type="checkbox"/> Resisting Communications | | | | <input type="checkbox"/> Normal |

EYES

- | | | | | |
|------------------------------------|---------------------------------|----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Closed | <input type="checkbox"/> Dilated | <input type="checkbox"/> Droopy | <input type="checkbox"/> Glassy |
| <input type="checkbox"/> Watery | | | | <input type="checkbox"/> Normal |

FACE

- | | | | | |
|----------------------------------|-------------------------------|---------------------------------|--|---------------------------------|
| <input type="checkbox"/> Flushed | <input type="checkbox"/> Pale | <input type="checkbox"/> Sweaty | | <input type="checkbox"/> Normal |
|----------------------------------|-------------------------------|---------------------------------|--|---------------------------------|

**APPEARANCE/
CLOTHING**

- | | | | | |
|---|---|--|-------------------------------|---------------------------------|
| <input type="checkbox"/> Bodily Excrement | <input type="checkbox"/> Stains on clothing | <input type="checkbox"/> Messy | <input type="checkbox"/> Neat | |
| <input type="checkbox"/> Strong Odor | <input type="checkbox"/> Soiled | <input type="checkbox"/> Partially Dressed | | <input type="checkbox"/> Normal |

BREATH

- | | | | |
|-------------------|---------------------------------|--------------------------------|-------------------------------|
| Odor - Alcohol: | <input type="checkbox"/> Strong | <input type="checkbox"/> Faint | <input type="checkbox"/> None |
| Odor - Marijuana: | <input type="checkbox"/> Strong | <input type="checkbox"/> Faint | <input type="checkbox"/> None |

MOVEMENTS

- | | | | | |
|-----------------------------------|--------------------------------------|--------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Fumbling | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Jerky | <input type="checkbox"/> Nervous | |
| <input type="checkbox"/> Slow | | | | <input type="checkbox"/> Normal |

EATING/CHEWING

- | | | | |
|--------------------------------|--------------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> Candy | <input type="checkbox"/> Mints | <input type="checkbox"/> Gum | <input type="checkbox"/> Nothing |
|--------------------------------|--------------------------------|------------------------------|----------------------------------|

