

**POST-ACCIDENT/REASONABLE SUSPICION TESTING & DOCUMENTATION
FORM
WASHINGTON CONSTRUCTION INDUSTRY SUBSTANCE ABUSE PROGRAM**

Employee's Name	Social Security No.	Date
<p>Type of Test: <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Suspicion</p>		
<input type="checkbox"/> Accident causing a fatality <input type="checkbox"/> Accident causing an injury requiring off-site medical attention <input type="checkbox"/> Accident causing significant property damage	<input type="checkbox"/> Observed drug/alcohol use <input type="checkbox"/> Difficulty maintaining balance <input type="checkbox"/> Slurred speech <input type="checkbox"/> Abnormal/erratic behavior <input type="checkbox"/> Apparent inability to safely perform assigned work <input type="checkbox"/> Additional observed behavior (Describe in detail)	
<p>Comments (<i>Describe the rationale for requesting testing, including observed facts and circumstances, any sources of information, date and time of observation or accident, other witnesses, actions taken, etc.</i>)</p> <hr/> <hr/> <hr/>		
Requester's Printed Name & Signature	Title	Date
Reviewer's Printed Name & Signature	Title	Date
<p>I acknowledge that I have been informed of the company's reasons for requesting this drug and alcohol test and consent to the testing. Signing this form does not necessarily signify agreement with the above statements.</p>		
Employee's Signature		Date