



Occupational Care Services Reasonable Suspicion Testing Checklist

| | |
|---|---------------------------|
| Employee Name: _____ | Employee Job Title: _____ |
| Facility: _____ | Location of Event: _____ |
| Observation Date: _____ Time: _____ a.m./p.m. | |
| Was employee performing a safety-sensitive duty? Yes No | |

The following observations were made of the employee identified above:

Check ALL specific and contemporaneous observations and document the following:

- | | | | |
|---|--|--|---|
| BEHAVIOR <input type="checkbox"/> unsteady gait, stumbling <input type="checkbox"/> drowsy, sleepy, lethargic <input type="checkbox"/> agitated, anxious, restless <input type="checkbox"/> hostile, belligerent <input type="checkbox"/> irritable, moody <input type="checkbox"/> depressed, withdrawn <input type="checkbox"/> unresponsive, distracted <input type="checkbox"/> clumsy, uncoordinated <input type="checkbox"/> tremors, shakes <input type="checkbox"/> flu-like illness complaints <input type="checkbox"/> suspicious, paranoid <input type="checkbox"/> hyperactive, fidgety <input type="checkbox"/> inappropriate, uninhibited behavior <input type="checkbox"/> frequent use of mints, mouthwash, breath sprays, eye drops | APPEARANCE <input type="checkbox"/> flushed complexion <input type="checkbox"/> flushed complexion <input type="checkbox"/> cold, clammy sweats <input type="checkbox"/> bloodshot eyes <input type="checkbox"/> tearing, watery eyes <input type="checkbox"/> dilated (large) pupils <input type="checkbox"/> constricted (pinpoint) pupils <input type="checkbox"/> unfocused, blank stare <input type="checkbox"/> disheveled clothing <input type="checkbox"/> unkempt appearance | SPEECH <input type="checkbox"/> slurred, thick <input type="checkbox"/> incoherent <input type="checkbox"/> exaggerated enunciation <input type="checkbox"/> loud, boisterous <input type="checkbox"/> rapid, pressured <input type="checkbox"/> excessively talkative <input type="checkbox"/> cursing, inappropriate speech <input type="checkbox"/> nonsensical, silly | BODY ODORS <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana |
|---|--|--|---|

Other observations: _____

Supervisor Name (print or type)
Additional witnesses (optional)

Supervisors Signature

Date

Witness Name (print or type)

Witness Signature

Date

TEST DETERMINATION

- | | | |
|--|--|--|
| <input type="checkbox"/> DOT | <input type="checkbox"/> NON-DOT | <input type="checkbox"/> NO Test Conducted |
| <input type="checkbox"/> Reasonable Suspicion Alcohol Test | <input type="checkbox"/> 8 hours elapsed for alcohol test | |
| <input type="checkbox"/> Reasonable Suspicion Drug Test | <input type="checkbox"/> 32 hours elapsed for drug test | |
| <input type="checkbox"/> No Test Required | <input type="checkbox"/> Employee transported for medical care | |
| <input type="checkbox"/> Employee Refused Test | <input type="checkbox"/> Other (explain): _____ | |

Company called Occupational Care Services at: (734) 278 - 1751 Yes No

Member of Occupational Care Services Employer Spoke To _____

Time of Call: _____ a.m./p.m. Occupational Care Services Collector: _____