

Post-Accident Drug Test Report Form

Employee information

Employee name:

Employee ID:

Job title:

Workplace and department:

Date of accident:

Time of accident:

Supervisor/manager information

Supervisor/manager name:

Date and time notified:

Accident details

Location of the accident:

Description of accident:

Witnesses (if any):

Drug test details

Date and time of test:

Category of testing:

Drug

Alcohol

Others, please specify:

Testing facility/location:
Test results: Positive Negative
If positive:
Type of drug or substance:
Level of drug/substance in body:
Employee statements
Manager/supervisor comments
Next steps moving forward

Authorization

I, _____, hereby authorize the release of the drug test results to the designated personnel within the organization.

Employee signature:	Date:
Supervisor/manager signature:	Date: