Post-Accident Drug Test Report Form

Employee Information:
Employee Name:
Employee ID:
Job Title:
Department:
Date of Accident:
Time of Accident:

Accident Details:
Location of Accident:
Description of Accident:
Witnesses (if any):

Supervisor/Manager Information:
Supervisor/Manager Name:
Date and Time Notified:

Drug Test Details:
Date and Time of Drug Test:
Testing Facility:

Categories of Substance Testing:

- [ ] Alcohol
- [ ] Illegal Drugs
- [ ] Prescription Medications

Employee Statements:

Observations and Notes:

Test Results:
☐ Negative ☐ Positive

If positive:

Supervisor/Manager Comments:

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:* _____