

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: