

Reasonable Cause/Reasonable Suspicion Testing Form

Please record the following information to document your reasonable cause/reasonable suspicion test determination.

Employee's Name: _____ Employee's ID/SSN: _____

Job Title: _____

Location of Incident: _____ Date: _____ Time Observed: _____

Trained Supervisor's Name & Signature: _____

Concurring Supervisor's Name & Signature: _____

Observations (Please check all that apply, and include descriptions of any *changes* in behavior.)

Appearance:

- | | | | |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Tremors/ Twitches | <input type="checkbox"/> Flushed or Pale | <input type="checkbox"/> Dilated Pupils |
| <input type="checkbox"/> Sleepy | <input type="checkbox"/> Sores/ Puncture Marks | <input type="checkbox"/> Heavy Eyelids | <input type="checkbox"/> Bloodshot eyes |
| <input type="checkbox"/> Disheveled | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Cleanliness | <input type="checkbox"/> Other (explain below) |

Description/Notes: _____

Behavior/ Demeanor:

- | | | | |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Erratic | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Lethargic |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Paranoid | <input type="checkbox"/> Verbally/Physically Abusive | <input type="checkbox"/> Highly Excited |
| <input type="checkbox"/> Confusion/Inattentive | <input type="checkbox"/> Combative | <input type="checkbox"/> Fatigue/ Sleeping/ Drowsiness | <input type="checkbox"/> Other (explain below) |

Description/Notes: _____

Motor Skills:

- | | | | | |
|-----------------------------------|---|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Swaying | <input type="checkbox"/> Falling | <input type="checkbox"/> Unbalanced | <input type="checkbox"/> Other (explain below) |
| <input type="checkbox"/> Unsteady | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Stumbling | |

Description/Notes: _____

Speech:

- | | | | |
|-------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Slurred | <input type="checkbox"/> Loud | <input type="checkbox"/> Other (explain below) |
| <input type="checkbox"/> Incoherent | <input type="checkbox"/> Exaggerated | <input type="checkbox"/> Talking Excessively | |

Description/Notes: _____

Odor:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Smell of Alcohol | <input type="checkbox"/> Excessive Cologne |
| <input type="checkbox"/> Body Odor | <input type="checkbox"/> Smell of Marijuana | <input type="checkbox"/> Other (explain below) |

Description/Notes: _____

Test Conducted: Yes No

Comments: _____