



# Report of Suspected Alcohol/Drug Impairment Form

In conjunction with DDSN's Drug-Free Workplace & Alcohol and Drug Testing for Employees Policy, this form is to be used whenever a covered worker (as defined by this policy) is suspected of being under the influence of alcohol or drugs, and objective observations support a "Reasonable Suspicion" screening test. The form should be completed as soon as possible when suspected policy violations are observed, and submitted to Human Resources for follow-up and confidential retention.

Name of Covered Worker Suspected of Alcohol/Drug Use: \_\_\_\_\_

Position or Job Function of this Covered Worker: \_\_\_\_\_

Regional Center, Facility, or Work Site: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Describe the activity, behavior or incident observed that prompted this report.**

Date(s) Observed: \_\_\_\_\_

Time(s) Observed: \_\_\_\_\_

Where Did this Happen? \_\_\_\_\_

**What objective evidence gives Reasonable Suspicion that a covered worker was under the influence of alcohol or drugs at the time of the observation or incident.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did you observe the covered worker do any of the following at a DDSN worksite, or while conducting business for DDSN?**

Yes  No

- Has Alcohol in Possession
- Has or Consumed Alcohol in Personal Vehicle
- Has or Used Drugs in Personal Vehicle
- Has Drug Paraphernalia in State Vehicle
- Provided Drug Paraphernalia to Others
- Has Drugs in Possession
- Has or Consumed Alcohol in State Vehicle
- Has or Used Drugs in State Vehicle
- Provided Alcohol or Drugs to Others
- Used Alcohol or Drugs Prior to Reporting to Work
- Has Drug Paraphernalia in Possession

**Is your report of Reasonable Suspicion based upon the physical appearance or behaviors of the covered worker, not one particular incident?**  Yes  No

- If "Yes," have you notified your (or the covered worker's) supervisor?  Yes  No
- If "Yes," please check the descriptions below that best indicate your observation.

**Walking/Standing**

Normal

- Stumbling
- Holding on to Items to Keep from Falling
- Swaying
- Unable to Stand
- Staggering
- Unable to Walk
- Falling Down
- Unsteady

**Speech**

Normal

- Shouting
- Whispering
- Used Profanity
- Slow
- Rambling
- Talks Nonsense
- Slurred
- Mumbling
- Constant Talking
- Incoherent
- Stammering
- Drooling

**Physical Appearance & Activity**

Normal

- Flushed Face       Facial Itching       Pale/Ashen Skin Complexion       Unusual Cuts, Bruises or Rashes
- Sweaty Face       Bloodshot Eyes       Dilated (Large) Pupils in Eyes       Pinpoint (Tiny) Pupils in Eyes
- Eyelid Tremors       Glassy Eyes       Light-Sensitive Eyes       Shaky/Trembles/Shivers
- Blank Stares       Watery Eyes       Faint Alcohol Odor on Breath       Strong Alcohol Odor on Breath
- Droopy Eyes       Very Red Eyelids       No Alcohol Odor on Breath       Smells of Marijuana or Other Drugs
- Bloody Nose       Vomiting/Nausea       Dry Mouth/White Lips       Impaired Driving Ability
- Stained Clothing       Messy/Untidy Appearance       Very Bad Body Odor

**Behavior**

Normal

- Sleepy       Suspicious of Others       Overly Worried       Crying       Frustrated/No Tolerance of Others
- Irritable       Sad/Withdrawn       Argumentative       Silent       Avoids Interaction with Others
- Confused       Over Reaction       Seems Disoriented       Acts Panicky       Unusual Giggling or Laughter
- Exhausted/ Weary       Excited/"Hyper"       Unusually "Silly"       Threatening/Violent Outbursts
- Mood Changes Significantly after Lunch or Break       Shortened Attention Span

Witness's Signature and Date \_\_\_\_\_

Name and Title of Person Recording Information, if Witness Prefers to Remain Anonymous \_\_\_\_\_

**Note:** If this Reasonable Suspicion of Drug and/or Alcohol Use is based upon the physical appearance or behaviors displayed by the covered worker, the supervisor, AOD, facility administrator or HR staff member should observe the worker him/herself. In such cases, a second witness should confirm the suspicions to warrant sending the covered worker to be tested for alcohol or drug use.

**Recommend Screening for Alcohol/Drug Use (or not)**

Supervisor of Covered Worker: \_\_\_\_\_ Date: \_\_\_\_\_ Recommended:  Yes  No

Facility Administrator: \_\_\_\_\_ Date: \_\_\_\_\_ Recommended:  Yes  No

Associate State Director: \_\_\_\_\_ Date: \_\_\_\_\_ Recommended:  Yes  No

District HR Director: \_\_\_\_\_ Date: \_\_\_\_\_ Recommended:  Yes  No

**To Be Completed by the HR Director or Designee**

Did Management Agree to Send Covered Worker to be tested for Drug/Alcohol Use?  Yes  No

If "Yes," Date & Time Scheduled for Testing: \_\_\_\_\_

Does Covered Worker Perform Safety-Sensitive Job Duties?  Yes  No

Did the Covered Worker Agree to be tested?  Yes  No