

## PRE-TEST DECLARATION FORM

This form is to be completed and carried to the drug testing site by the employee. After the specimen collector has entered the Confidential Test Number on the form, the employee should place the completed form in a stamped and pre-addressed envelope provided by the department, which should also contain a copy of the Reasonable Suspicion Checklist. A departmental representative shall promptly send the sealed envelope to the Medical Review Officer. The employee may witness the mailing.

Employee Name: \_\_\_\_\_

**Instruction:** List any prescription or over-the-counter non-prescription medications you are now taking or have taken during the last thirty (30) days. Specify the reason for the medication(s), the amount last taken and the date. Also, indicate the name of the health care provider prescribing any medication(s).

Medication	Date Last Taken	Amount/Dose
Name of Prescribing Health Care Provider <i>(if prescribed)</i>		Office Location

Medication	Date Last Taken	Amount/Dose
Name of Prescribing Health Care Provider <i>(if prescribed)</i> _____ <i>(check if same as above)</i>		Office Location _____ <i>(check if same as above)</i>

**List any additional medications on back of form.**

Have you ingested, inhaled or absorbed any controlled substance within the last ten (10) days in connection with your employment?

( ) No  
 ( ) Yes    Date(s) of exposure \_\_\_\_\_ Substance \_\_\_\_\_

I certify that the information provided is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If follow-up is necessary, a reliable telephone number for contact or message is:

( ) \_\_\_\_\_