



Policy Number 401.33R2

Reasonable Suspicion Documentation Form

Employee Name _____ Job Title _____
 Region _____ Regional Office _____
 Location of Incident _____ Date _____
 Time Observed _____ Reporting Supervisor _____

Trained Supervisor's Signature _____ Date _____

HR Director/Designee Signature _____ Date _____

Observations

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)

Description/Notes: _____

Behavior:			
<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/Drowsiness	<input type="checkbox"/> Other (explain)

Description/Notes: _____

Motor Skills:			
<input type="checkbox"/> Normal	<input type="checkbox"/> Swaying	<input type="checkbox"/> Falling	<input type="checkbox"/> Unbalanced
<input type="checkbox"/> Unsteady	<input type="checkbox"/> Lack of Coordination	<input type="checkbox"/> Fidgety	<input type="checkbox"/> Stumbling
<input type="checkbox"/> Other (Explain)			

Description/Notes: _____

Speech:			
<input type="checkbox"/> Normal	<input type="checkbox"/> Slurred	<input type="checkbox"/> Loud	<input type="checkbox"/> Incoherent
<input type="checkbox"/> Exaggerated	<input type="checkbox"/> Excessive Talking	<input type="checkbox"/> Other (explain)	

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)		

Description/Notes: _____

Drug and Alcohol Test Conducted: ___yes ___no