

**REASONABLE SUSPICION TESTING REPORT (Cont)
EMPLOYEE INTERVIEW**

Employee Name: _____ Date: _____

- ARE YOU ILL HAVE YOU SEEN A DOCTOR/DENTIST RECENTLY? WHEN _____
- WHO _____ PURPOSE _____
- ARE YOU TAKING MEDICINE? WHAT _____ LAST DOSE _____ AM/PM
- DO YOU HAVE DIABETES? ARE YOU TAKING INSULIN?
- HAVE YOU USED MOUTHWASH RECENTLY?
- ARE YOU HURT? WHERE _____
- HOW MUCH SLEEP DID YOU GET LAST NIGHT? _____ TODAY? _____
- HAVE YOU BEEN DRINKING USING DRUGS WHAT KIND _____

CHECK THE WORDS DESCRIBING OBSERVED CONDITIONS. ADD OTHER WORDS OF YOUR OWN.)

BREATH - ODOR OR ALCOHOLIC LIQUOR	<input type="checkbox"/> NONE	<input type="checkbox"/> FAINT	<input type="checkbox"/> MODERATE	<input type="checkbox"/> STRONG
COLOR OF FACE	<input type="checkbox"/> NORMAL	<input type="checkbox"/> FLUSHED	<input type="checkbox"/> PALE	<input type="checkbox"/> OTHER
ATTITUDE	<input type="checkbox"/> POLITE	<input type="checkbox"/> EXCITED	<input type="checkbox"/> HILARIOUS	<input type="checkbox"/> TALKATIVE
	<input type="checkbox"/> SLEEPY	<input type="checkbox"/> COOPERATIVE	<input type="checkbox"/> INDIFFERENT	<input type="checkbox"/> ANTAGONISTIC
	<input type="checkbox"/> COCKY	<input type="checkbox"/> COMBATIVE	<input type="checkbox"/> INSULTING	<input type="checkbox"/> OTHER: _____
UNUSUAL ACTIONS:	<input type="checkbox"/> PROFANITY	<input type="checkbox"/> HICCOUGH	<input type="checkbox"/> BELCHING	<input type="checkbox"/> VOMITING
	<input type="checkbox"/> FIGHTING	<input type="checkbox"/> OTHER _____		
EYES:	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WATERY	<input type="checkbox"/> BLOODSHOT	<input type="checkbox"/> OTHER
PUPILS:	<input type="checkbox"/> NORMAL	<input type="checkbox"/> DIALATED	<input type="checkbox"/> CONTRACTED	<input type="checkbox"/> POOR REACTION TO LIGHT
BALANCE:	<input type="checkbox"/> FAIR	<input type="checkbox"/> SURE	<input type="checkbox"/> SWAYING	<input type="checkbox"/> WOBBLING
	<input type="checkbox"/> SAGGING	<input type="checkbox"/> FALLING	<input type="checkbox"/> OTHER _____	
WALKING:	<input type="checkbox"/> FAIR	<input type="checkbox"/> SURE	<input type="checkbox"/> SWAYING	<input type="checkbox"/> STUMBLING
	<input type="checkbox"/> FALLING	<input type="checkbox"/> OTHER _____		<input type="checkbox"/> STAGGERING
SPEECH:	<input type="checkbox"/> FAIR	<input type="checkbox"/> SLURRED	<input type="checkbox"/> STUTTERING	<input type="checkbox"/> CONFUSED
				<input type="checkbox"/> INCOHERENT

ADDITIONAL COMMENTS REGARDING EMPLOYEES DISPOSITION OR ACTIONS DURING INTERVIEW:

WITNESSES (TWO SUPERVISORS REQUIRED):

Date	Supervisor Signature	Supervisor Printed Name	Phone Number
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Date	Supervisor Signature	Supervisor Printed Name	Phone Number
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