## **Drug Test Results Form**

Facility information				
Date:				
Test facility name:				
Address:				
Contact:				
Employee/patient information				
Name:		Date of birth:		
Employee/Patient ID:	nt ID:		Contact number:	
Testing details				
Type of test:		Collection date and time:		
Collection site:		Testing method:		
Drug panel				
Substance	Result	t	Cutoff level	

Substance	Result	Cutoff level		
Comments and notes				
Certification				
I, the undersigned, certify that the above information is accurate and complete to the best of my knowledge. I understand that any falsification or misrepresentation may result in appropriate actions as per the organization's policies.				
Name:				
Signature:				
Date:				