Date:_____ **Time of Observation:**_____
(From – To)

Observed Behavior(s):

(Check all that apply)

- ☐ Slurred Speech
- ☐ Disorientation
- ☐ Nausea/Vomiting
- ☐ Bloodshot/Watery Eyes
- ☐ Dangerous Behavior
- ☐ Driving Erratically
- ☐ Insubordinate
- ☐ Aggravated/Belligerent
- ☐ Unusually Excited/Nervous
- ☐ Extreme Fatigue/Sleepiness on Job
- ☐ Unusual wear of shaded glasses
- ☐ Odor of Alcohol/Marijuana
- ☐ Poor Coordination
- ☐ Pale/Clammy Skin
- ☐ Unusual Eye Movement/Dilation/Constriction
- ☐ Dry Mouth
- ☐ Post-Accident

Other_____

Notes:_____
_____
_____
_____

First Observer_____ **Second Observer**_____
(Signature) (Signature)