County of Los Angeles
Department of Human Resources – Occupational Health Programs

PRE - TEST DECLARATION FORM

Instructions to Supervisor:

This form is to be completed and carried to the drug testing site by the employee and given to the clinic staff.

Employee Name: _____

Instructions to Employee:

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 medication, date last taken, amount/dose and the reason for the medication(s).

Medication	Date Last Taken	Amount/Dose	Reason

Have you ingested or inhaled any illegal substance within the last ten (10) days?

( ) No

( ) Yes Date(s) of usage _____Substance_____

Please provide a reliable telephone number for contact or message and your mailing address.

( ) _____

_____

_____

The above information provided is true and correct to the best of my knowledge.

Signature: _____

Date: _____

Note to Clinic Staff: Copy to Employee
Original to be mailed to OHP by clinic

Revised 1/16/2020 nab