STATE OF WASHINGTON
Department of
Licensing

EMPLOYER REPORT OF POSITIVE/REFUSED DRUG/ALCOHOL TEST

RCW 46.25.123

DRIVER'S NAME *(Last, First, Middle Initial)*		DATE OF BIRTH *(If available)*
DRIVER LICENSE NUMBER *(If available)*	SOCIAL SECURITY NUMBER	
EMPLOYER/ MOTOR CARRIER/CONSORTIUM NAME		(AREA CODE) TELEPHONE NUMBER
EMPLOYER/ MOTOR CARRIER/CONSORTIUM MAILING ADDRESS		
CITY	STATE	ZIP

REASON FOR TEST

☐ Pre-employment ☐ Random ☐ Reasonable suspicion ☐ Post accident ☐ Return to duty ☐ Follow-up

ATTESTATION

As the employer, motor carrier, or consortium, having a program subject to the federal requirements under 49 CFR 40, I declare that the driver above has:

☐ tested positive for: ☐ drug(s) ☐ alcohol
☐ refused test

I further declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

X _____
SIGNATURE

_____
DATE SIGNED PLACE SIGNED

Mail or fax to: Department of Licensing, Mandatory Suspensions, PO Box 9030, Olympia, WA 98507-9030, (360) 902-3802.

The Department of Licensing has a policy of providing equal access to its services.
If you need special accommodation call (360) 902-3900 or TTY (360) 664-0116.