DRUG TESING
MANAGEMENT INFORMATION SYSTEM (MIS)
DATA COLLECTION FORM

This Management Information System (MIS) form is to be completed on the last day of each quarter in accordance with the Drug-Free Workplace operating procedures as part of the annual report to the Governor.

PART A: DEPARTMENT OF ADMINISTRATION *(To be completed by the DFWP Coordinator / EAP Administrator)*

Department/Agency Name: _____

Department/Agency Mailing Address: _____

Designated Representative Name: _____

Position Title: _____ **Telephone:** _____

Designated Representative Signature: _____

Designated Representative Email: _____

Appointing Authority Name: _____

Appointing Authority Signature: _____

Coverage Start Date: _____ **Coverage End Date:** _____

PART B: DEPARTMENT/AGENCY *(To be completed by the Department/Agency EAP Representative)*

Type of Test	Verified Number of Negative Drug Test	Verified Number of Positive Drug Test	Verified Number of Positive for Marijuana	Verified Number of Positive for Cocaine	Verified Number of Positive for PCP	Verified Number of Positive for Opiates	Verified Number of Positive for Amphetamines	Verified Number of Diluted Drug Test Results	Verified Number of Refusal to Test	Number of Employee Referred through Employee Assistance Program (EAP)	Number of Employees completed the Employee Assistance Program (EAP)	Number of Employees dismissed via Adverse Action	Number of Employees / applicants cancelled employment offer due to drug test	Number of Employees resigned as a results of drug test
Pre-Employment														
Random														
Reasonable Suspicion														
Post-Accident														
Follow-Up														
Total														

PART E: DEPARTMENT OF ADMINISTRATION (*To be completed by the DFWP Coordinator / EAP Administrator)*

_____ Signature of DOA DFWP Coordinator Receipt / EAP Administrator	DFWP – EAP STAMP RECEIVED: