ATTACHMENT B

DRUG TESTING
MEDICATION INFORMATION

As part of the drug testing process, it is essential that you inform us of all medications you have taken in the last fourteen (14) days. Please *carefully* complete the information below.

✓ all that apply:

☐ A. During the past 14 days I have taken the following medication prescribed by a physician:

	Name of Medication	Prescribing Physician	Date Last Taken
1			
2			
3			

☐ B. During the past 14 days, I have taken the following non-prescription medications (cough medicine, cold tablets, aspirin, diet medication, nutritional supplements, etc.)

	Non-Prescription Medication	Date Last Taken
1		
2		
3		

☐ C. During the past 14 days, I have taken **NO** prescription or non-prescription medications.

Social Security Number & Initials _____ Date _____

Signature of Witness _____ Date _____