

REQUEST FOR TEST OF SUSPECTED CONTRABAND DRUGS

Inmate Name		Number		Cell	
Request made by			Date		
Substance suspected			Approximate amount		
Circumstances leading to request					
(continue on back if additional space is needed)					
Supervisor receiving request				Date	
If a capsule, was it inspected at at pharmacy?		Inspected by		Date	Time
Yes <input type="checkbox"/>					
No <input type="checkbox"/>					
Substance tested by				Date	Time
Results					
Method of testing					
Was any of the substance left after testing?		Was remaining substance forwarded to State Police lab?		Date	Time
Yes <input type="checkbox"/>		Yes <input type="checkbox"/>			
No <input type="checkbox"/>		No <input type="checkbox"/>			
Manner		Results		Date	

CHAIN OF CUSTODY (Starting with the officer who found the substance)

From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____
From _____	To _____	Date _____	Time _____

This form is to be filled out completely. It is to accompany the suspected substance until the substance is tested. After the substance is tested, this form is to be delivered to the office responsible for inmate discipline regardless of the results. If the substance proves to be a contraband drug, a misbehavior report shall be written.