

SPECIMEN ID NO.

Version C 14May2010

000001

STEP 1: COMPLETED BY COLLECTOR OR EI	MPLOYER REPRESENTATIVE		ACCESSIC	NN NO.
A. Employer Name, Address, I.D. No.	B. MRO	Name, Addres	ss, Phone No. and F	ax No.
C. Donor SSN or Employee I.D. No.				
D. Specify Testing Authority: HHS NR	C DOT – Specify DOT Agency:	FMCSA [☐ FAA ☐ FRA	☐ FTA ☐ PHMSA ☐ USCG
E. Reason for Test: Pre-employment Randor				
F. Drug Tests to be Performed: THC, CO	C, PCP, OPI, AMP THC & COC Only	Other	(specify)	
G. Collection Site Address:		Coll	ector Phone No	
STEP 2: COMPLETED BY COLLECTOR (make	remarks when appropriate) Collector re		ector Fax No	
			None Provided, Enter	
REMARKS				
STEP 3: Collector affixes bottle seal(s) to bot	tle(s) Collector dates seal(s) Donor initi	ale epal(e) Do	onor completes ST	FP 5 on Cony 2 (MRO Cony)
STEP 4: CHAIN OF CUSTODY - INITIATED BY	COLLECTOR AND COMPLETED BY TES	T FACILITY	•	
I certify that the specimen given to me by the donor collected, labeled, sealed and released to the Delivery S			SPECIMI	EN BOTTLE(S) RELEASED TO:
x				
Signa	ature of Collector	AM		
(PRINT) Collector's Name (First, MI, Last)		PM of Collection		Name of Delivery Service
RECEIVED AT LAB OR IITF:			Primary Specimen Bottle Seal Intact	SPECIMEN BOTTLE(S) RELEASED TO
X Signati	ure of Accessioner		☐ YES ☐ NO	
(PRINT) Accessioner's Name	o (First ML Loot)	/ / ate (Mo/Day/Yr)	If NO, Enter remark in Step 5A.	
STEP 5A: PRIMARY SPECIMEN REPORT - CO		ite (WO/Day/11)	пт этер эд.	
DILUTE	r:	6-Acetylmo	nine A Sodeine	amphetamine
Test Facility (if different from above) :				
I certify that the specimen identified on this form was exan	nined upon receipt, handled using chain of custody p	rocedures, analyz	red, and reported in acco	ordance with applicable Federal requirement
X Signature of Certifying Technician/Scie	(DDINT) Caratiful	an Tanhainina (Cair	autich's Name (First MI I	.ast)
STEP 5b: COMPLETED BY SPLIT TESTING LA		ng rechnician/Scie	entist's Name (First, MI, L	ast) Date (MO/Day/11)
Laboratory Name	□ RECONFIRMED □ FAILED TO RECONF I certify that the split specimen identified on this for and reported in accordance with applicable Federal r	rm was examined		ısing chain of custody procedures, analyzed,
Laboratory Address	Signature of Certifying Scientist	(PRINT) C	ertifying Scientist's Name	(First, MI, Last) Date (Mo./Day/Yr.)
0000001 SPECIMEN ID NO.	PLACE OVER CAP	SPE	0000001 ECIMEN BOTTL SEAL	Date (Mo/Day/Yr) Donor's Initials
0000001 (SPLI		SPE	0000001 ECIMEN BOTTL SEAL	Date (Mo/Day/Yr) Donor's Initials

PECIMEN ID NO. 000001

TEP 1: COMPLETED BY COLLEC			D MDO N	ACCESSION NO.	
A. Employer Name, Address, I.D. No).		B. MRO Name, Addre	ss, Phone No. and Fax No.	
c. Donor SSN or Employee I.D. No.					
D. Specify Testing Authority: H				 □ FAA □ FRA □ FTA □	□ PHMSA □ USCG
E. Reason for Test: Pre-employment		. , ,	, _		
Drug Tests to be Performed:					ony)
G. Collection Site Address:					
a. Contolion Cito / taarooo.			Col	llector Phone No	
			Col	llector Fax No.	
TEP 2: COMPLETED BY COLLEC	CTOR (make remarks whe	en appropriate) Coll			S.
emperature between 90° and 100° F?				None Provided, Enter Remark	Observed, Enter Remark
REMARKS					
TEP 3: Collector affixes bottle se				onor completes STEP 5 on Co	py 2 (MRO Copy)
TEP 4: CHAIN OF CUSTODY - INI certify that the specimen given to me				SPECIMEN BOTTLE(S	\ DELEASED TO:
collected, labeled, sealed and released to) NELEAGED TO.
Y					
^	Signature of Collector		AM		
			PM		
(PRINT) Collector's Name TEP 5: COMPLETED BY DONOR		Date (Mo/Day/Yr)	Time of Collection	Name of Deliver	y Service
Signature of E		Evening Phone No.	(PRINT) Donor's Name		/ / Date (Mo/Day/Yr)
Daytime Phone No. ()		Evening Phone No)	Date of Birth	(Mo/Day/Yr)
After the Medical Review Officer in over-the-counter medications you NECESSARY. If you choose to m NFORMATION ON THE BACK CONTER BY MEDICA In accordance with applicable Federa.	u may have taken. Therefor take a list, do so either of DF ANY OTHER COPY C LL REVIEW OFFICER - PF	ore, you may want to n a separate piece OF THE FORM. TAK RIMARY SPECIMEN	o make a list of those of paper or on the b	e medications for your own rec eack of your copy (Copy 5). – [ords. THIS LIST IS NO
	or:				
DILUTE					
REFUSAL TO TEST because – o ADULTERATED (adulter	` '			☐ TEST CANC	ELLED
SUBSTITUTED	uni/1000011).				
_					
REMARKS:					
X Signature of Medica	J. Pavian Officer		DINT\ Madical Davious Office	ou's Name (First MI Lost)	
STEP 7: COMPLETED BY MEDICA	L REVIEW OFFICER - SF	LIT SPECIMEN	RINT) Medical Review Offic	er's Name (First, MI, Last)	Date (Mo/Day/Yr)
n accordance with applicable Federa	I requirements, my verification	on for the split specim	en (if tested) is:		
RECONFIRMED for:				TEST CANC	ELLED
FAILED TO RECONFIRM fo	r:				
REMARKS:					
<u></u>					
Signature of Medica	I Review Officer	(P	RINT) Medical Review Offic	er's Name (First, MI, Last)	Date (Mo/Day/Yr)

SPECIMEN ID NO. 000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REP	RESENTATIVE ACCESSION NO.
A. Employer Name, Address, I.D. No.	B. MRO Name, Address, Phone No. and Fax No.
C. Donor SSN or Employee I.D. No	
E. Reason for Test: Pre-employment Random Reasonable	- Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)
G. Collection Site Address:	Collector Phone No
	Callantan Fav. Na
TEP 2: COMPLETED BY COLLECTOR (make remarks when	Collector Fax Non appropriate) Collector reads specimen temperature within 4 minutes.
Temperature between 90° and 100° F? Yes No, Enter Remark REMARKS	
TEP 3: Collector affixes bottle seal(s) to bottle(s). Collector TEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR A certify that the specimen given to me by the donor identified in the certify that the specimen given to me by the donor identified in the certify that the specimen given to me by the donor identified in the certify that the specimen given to me by the donor identified in the certification.	
certify that the specimen given to the by the donor identified in the co- collected, labeled, sealed and released to the Delivery Service noted in ac	
Signature of Collector	AM / / PM
(PRINT) Collector's Name (First, MI, Last) TEP 5: COMPLETED BY DONOR	Date (Mo/Day/Yr) Time of Collection Name of Delivery Service
certify that I provided my urine specimen to the collector; that I have any presence; and that the information provided on this form and on Signature of Donor	(PRINT) Donor's Name (First, MI, Last) // Date (Mo/Day/Yr)
After the Medical Review Officer receives the test results for over-the-counter medications you may have taken. Therefor	vening Phone No Date of Birth//
TEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRII n accordance with applicable Federal requirements, my verification	n is:
NEGATIVE	☐ TEST CANCELLED
ADULTERATED (adulterant/reason):SUBSTITUTEDOTHER:	
REMARKS:	
Signature of Medical Review Officer	
In accordance with applicable Federal requirements, my verification RECONFIRMED for:	<u>_</u>
FAILED TO RECONFIRM for:	
REMARKS:	
v	
Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/Day/Yr)

PECIMEN ID NO. 000001

TEP 1: COMPLETED BY COLLEC		TNESENIATIVE	D MDO N	ACCESSION NO.	
A. Employer Name, Address, I.D. No).		B. MRO Name, Addre	ess, Phone No. and Fax No.	
. Donor SSN or Employee I.D. No.					
D. Specify Testing Authority: H				 □ FAA □ FRA □ FTA	□ PHMSA □ LISCG
. Reason for Test: Pre-employment		, , ,	,		
Drug Tests to be Performed:				r (specify)	
i. Collection Site Address:			,	· · · · · · · · · · · · · · · · · · ·	
			Со	llector Phone No	
TEP 2: COMPLETED BY COLLEC	CTOR (make remarks whe	n appropriate) Col		llector Fax No	tes
emperature between 90° and 100° F?				None Provided, Enter Remark	Observed, Enter Remark
EMARKS					
TEP 3: Collector affixes bottle se TEP 4: CHAIN OF CUSTODY - INI				•	
certify that the specimen given to me of collected, labeled, sealed and released to					(S) RELEASED TO:
(•				
	Signature of Collector		AM		
(PRINT) Collector's Name	e (First, Ml. Last)	// Date (Mo/Day/Yr)	Time of Collection	Name of Deli	very Service
ry presence; and that the information Signature of E	•	n the label affixed to	each specimen bottle is (PRINT) Donor's Name		/ Date (Mo/Day/Yr)
	E	Evening Phone No.		Date of Bir	th/ /(Mo/Day/Yr)
After the Medical Review Officer in over-the-counter medications you because to make the Medical of the Medical	i may have taken. Therefor take a list, do so either or DF ANY OTHER COPY O L REVIEW OFFICER - PR	ore, you may want to n a separate piece of THE FORM. TAN IMARY SPECIMEN	o make a list of thos of paper or on the b KE COPY 5 WITH YO	he/she may contact you to as e medications for your own re back of your copy (Copy 5). –	sk about prescriptions an ecords. THIS LIST IS NO
	or:				
☐ DILUTE ☐ REFUSAL TO TEST because – c	sheck reason(s) helow:			☐ TEST CAN	CELLED
☐ ADULTERATED (adulter	` '				
REMARKS:					
					/ /
Signature of Medica TEP 7: COMPLETED BY MEDICA	L REVIEW OFFICER - SP	LIT SPECIMEN	PRINT) Medical Review Office	eer's Name (First, MI, Last)	Date (Mo/Day/Yr)
n accordance with applicable Federa	I requirements, my verification	n for the split specim	en (if tested) is:		
RECONFIRMED for:				TEST CAN	CELLED
☐ FAILED TO RECONFIRM fo	r:				
REMARKS:					
{					/ /
Signature of Medica	I Review Officer	(F	PRINT) Medical Review Office	er's Name (First, MI, Last)	Date (Mo/Day/Yr)

	BACK COPIES 1-4	
\bigcirc	Public Burden Statement:	
\bigcirc	An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0158. Public reporting burden for this collection of information is estimated to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville,	
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PECIMEN ID NO. 000001

	TOR OR EMPLOYER R	LITILOLIVIATIVE	D MDO M	ACCESSION	
A. Employer Name, Address, I.D. No.			B. MRO Name, Ad	Idress, Phone No. and Fax	No.
. Donor SSN or Employee I.D. No					
. Specify Testing Authority: HH					FTA PHMSA USCG
. Reason for Test: Pre-employmen					
Drug Tests to be Performed:] THC, COC, PCP, OPI,	AMP THC &	COC Only	ther (specify)	
. Collection Site Address:					
				Collector Phone No	
				Collector Fax No	
TEP 2: COMPLETED BY COLLEC					
emperature between 90° and 100° F?	Yes No, Enter Rem	nark Collection:	Split Single	None Provided, Enter Re	mark Observed, Enter Remai
FEP 3: Collector affixes bottle sea					5 on Copy 2 (MRO Copy)
certify that the specimen given to me b	by the donor identified in th	ne certification section of	n Copy 2 of this form	was SPECIMEN	BOTTLE(S) RELEASED TO:
ollected, labeled, sealed and released to	the Delivery Service noted in	n accordance with applic	able Federal requireme	ents.	
	Signature of Collector				
	g			AM PM	
(PRINT) Collector's Name	(First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection	Nai	ne of Delivery Service
TEP 5: COMPLETED BY DONOR certify that I provided my urine specin	men to the collector: that I	I have not adulterated	it in anv manner: eac	h specimen bottle used was	sealed with a tamper-evident seal
ny presence; and that the information					ocalea mir a lamper erraem ecal
(1 1
Signature of Do			, ,	ame (First, MI, Last)	Date (Mo/Day/Yr)
aytime Phone No. ()		Evening Phone No.	()	Dat	e of Birth/(Mo/Day/Yr)
after the Medical Review Officer rever-the-counter medications you	may have taken. There	efore, you may want	to make a list of th	m, he/she may contact yo nose medications for your	ou to ask about prescriptions a own records. THIS LIST IS NO
NECESSARY. If you choose to ma NFORMATION ON THE BACK O	ake a list, do so either F ANY OTHER COPY	on a separate piece 'OF THE FORM. TA	e of paper or on th KE COPY 5 WITH	ie back of your copy (Cop LYOU.	by 5). – DO NOT PROVIDE TH
TEP 6: COMPLETED BY MEDICAL	L REVIEW OFFICER - F	PRIMARY SPECIME			
accordance with applicable Federal	requirements, my verifica	ition is:			
NEGATIVE DILUTE	r:				
REFUSAL TO TEST because – ch	heck reason(s) below:			□TES	T CANCELLED
ADULTERATED (adultera	` '			_	71 0711102222
SUBSTITUTED					
☐ OTHER:					
REMARKS:					
Ciamatura of Madical	Review Officer		(DDINT) Madical Daview	Officer's Name (First, MI, Last)	
TEP 7: COMPLETED BY MEDICAL	L REVIEW OFFICER - S	SPLIT SPECIMEN	(PRINT) Medical Review	Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
	requirements, my verifica	tion for the split specin	nen (if tested) is:		
accordance with applicable Federal					T CANCELLED
n accordance with applicable Federal RECONFIRMED for:				LIES	
n accordance with applicable Federal RECONFIRMED for: FAILED TO RECONFIRM for					
RECONFIRMED for:	":				
RECONFIRMED for:	":				
RECONFIRMED for:	":				

BACK COPY 5

Instructions for Completing the Federal Drug Testing Custody and Control Form

When making entries use black or blue ink pen and press firmly

Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory are on the top of the CCF and that the Specimen I.D. number on the top of the CCF matches the Specimen I.D. number on the labels/seals.

STEP 1:

- Collector ensures that the required information is in STEP 1. Collector enters a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee I.D. number.
- Collector gives collection container to Donor and instructs Donor to provide a specimen. Collector notes any unusual behavior or appearance of Donor in the remarks line in STEP 2. If Donor conduct at any time during the collection process clearly indicates an attempt to tamper with the specimen, Collector notes the conduct in the remarks line in STEP 2 and takes action as required.

STEP 2:

- Collector checks specimen temperature within 4 minutes after receiving the specimen from Donor, and marks the appropriate temperature box in STEP 2. If temperature is outside the acceptable range, Collector enters a remark in STEP 2 and takes action as required.
- Collector inspects the specimen and notes any unusual findings in the remarks line in STEP 2 and takes action as required. Any specimen with unusual physical characteristics (e.g. unusual color, presence of foreign objects or material, unusual odor) cannot be sent to an IITF and must be sent to an HHS-certified laboratory for testing as required.
- Collector determines the volume of specimen in the collection container. If the volume is acceptable, Collector proceeds with the
 collection. If the volume is less than required by the Federal Agency, Collector takes action as required, and enters remarks in
 STEP 2. If no specimen is collected by the end of the collection process, Collector checks the *None Provided* box, enters a remark
 in STEP 2, discards Copy 1 and distributes remaining copies as required.
- Collector checks the Split or Single specimen collection box. If the collection is observed, Collector checks the Observed box and enters a remark in STEP 2.

STEP 3:

- Donor watches Collector pour the specimen from the collection container into the specimen bottle(s), place the cap(s) on the specimen bottle(s), and affix the label(s)/seal(s) on the specimen bottle(s).
- Collector dates the specimen bottle label(s)/seal(s) after placement on the specimen bottle(s).
- Donor initials the specimen bottle label(s)/seal(s) after placement on the specimen bottle(s).
- Collector turns to Copy 2 (Medical Review Officer Copy) and instructs Donor to read and complete the certification statement in STEP 5 (signature, printed name, date, phone numbers, and date of birth). If Donor refuses to sign the certification statement, Collector enters a remark in STEP 2 on Copy 1.

STEP 4:

• Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service), places the sealed specimen bottle(s) and Copy 1 of the CCF in a leak-proof plastic bag, seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required.

Privacy Act Statement: (For Federal Employees Only)

Submission of the information on the attached form is voluntary. However, incomplete submission of the information, refusal to provide a urine specimen, or substitution or adulteration of a specimen may result in delay or denial of your application for employment/appointment or may result in removal from the Federal service or other disciplinary action.

The authority for obtaining the urine specimen and identifying information contained herein is Executive Order 12564 ("Drug-Free Federal Workplace"), 5 U.S.C. Sec. 3301 (2), 5 U.S.C. Sec. 7301, and Section 503 of Public Law 100-71, 5 U.S.C. Sec. 7301 note. Under provisions of Executive Order 12564 and 5 U.S.C. 7301, test results may only be disclosed to agency officials on a need-to-know basis. This may include the agency Medical Review Officer (MRO), the administrator of the Employee Assistance Program, and a supervisor with authority to take adverse personnel action. This information may also be disclosed to a court where necessary to defend against a challenge to an adverse personnel action.

Submission of your SSN is not required by law and is voluntary. Your refusal to furnish your number will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited, pursuant to Executive Order 9397, for purposes of associating information in agency files relating to you and for purposes of identifying the specimen provided for testing. If you refuse to indicate your SSN, a substitute number or other identifier will be assigned, as required, to process the specimen.

Public Burden Statement:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0158. Public reporting burden for this collection of information is estimated to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.