

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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. _____

D. Specify Testing Authority: HHS NRC DOT – Specify DOT Agency: FMCSA FAA FRA FTA PHMSA USCG

E. Reason for Test: Pre-employment Random Reasonable Suspicion/Cause Post Accident Return to Duty Follow-up Other (specify) _____

F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP THC & COC Only Other (specify) _____

G. Collection Site Address: _____

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? Yes No, Enter Remark _____ Collection: Split Single None Provided, Enter Remark _____ Observed, Enter Remark _____

REMARKS _____

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

SPECIMEN BOTTLE(S) RELEASED TO:

X _____ AM
Signature of Collector _____ PM

(PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____ Time of Collection _____ Name of Delivery Service _____

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X _____
Signature of Donor _____ (PRINT) Donor's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____

Daytime Phone No. (_____) _____ Evening Phone No. (_____) _____ Date of Birth _____
(Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

NEGATIVE **POSITIVE** for: _____
 DILUTE

REFUSAL TO TEST because – check reason(s) below: **TEST CANCELLED**

ADULTERATED (adulterant/reason): _____

SUBSTITUTED

OTHER: _____

REMARKS: _____

X _____
Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

RECONFIRMED for: _____ **TEST CANCELLED**

FAILED TO RECONFIRM for: _____

REMARKS: _____

X _____
Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____