FEDERAL DRUG TESTING CUSTODY AND CON	NTROL FORM
SPECIMEN ID NO. 000001 AC	CCESSION NO.
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE	
A. Employer Name, Address, I.D. No. B. MRO Name, Addr	ess, Phone No. and Fax No.
C. Donor SSN or Employee I.D. No. We are adding CDL State and No. as an option for donor id	entification here
	☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
E. Reason for Test: Pre-employment Random Reasonable Suspicion/Cause Post Accident R	eturn to Duty Follow-up Other (specify)
	er (specify)
G. Collection Site Address: Collector Contac	t Info: Phone
	Fax Other
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).	
COLLECTION: Split Single None Provided, Enter Remark, We are adding a horizont	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F?	
ORAL FLUID: Split Type: Serial Concurrent Subdivided Each Device Within Expiration	
REMARKS:	
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). 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 for	
was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable federal requiren	nents.
X	_
Signature of Collector Al	M
(PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection	Name of Delivery Service
	Primary Specimen SPECIMEN BOTTLE(S)/TUBE(S)
RECEIVED AT LAB OR IITF:	
X	Seal Intact RELEASED TO:
RECEIVED AT LAB OR IITF: X Signature of Accessioner	
X	Seal Intact RELEASED TO:
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)	Seal Intact RELEASED TO:
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) // Primary/Single Specimen Device Expiration Date: // (Mo/Day/Yr) Split Specime	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark in Step 5A. ////////////////////////////////////
Signature of Accessioner	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark in Step 5A. ////////////////////////////////////
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / / (Mo/Day/Yr) Split Specime STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY NEGATIVE REJECTED FOR TESTING DILUTE	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark in Step 5A. (Mo/Day/Yr)
Signature of Accessioner	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark in Step 5A. (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / / (Mo/Day/Yr) Split Specime STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY NEGATIVE REJECTED FOR TESTING DILUTE POSITIVE for: Analyte(s) in ng/mL REMARKS:	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark in Step 5A. (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / / (Mo/Day/Yr) Split Specime STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY NEGATIVE REJECTED FOR TESTING DILUTE POSITIVE for: Analyte(s) in ng/mL	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark In Device Expiration Date: / (Mo/Day/Yr) SUBSTITUTED
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / (Mo/Day/Yr) Split Specime STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY NEGATIVE REJECTED FOR TESTING DILUTE Adulterated Image: POSITIVE for: Analyte(s) in ng/mL REMARKS: Test Facility (if different from above) :	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark In Device Expiration Date: / (Mo/Day/Yr) SUBSTITUTED
X Signature of Accessioner Image: constraint of the specimen device of the speci	Seal Intact RELEASED TO: YES NO If NO, Enter remark If NO, Enter remark In Device Expiration Date: / (Mo/Day/Yr) SUBSTITUTED
X Signature of Accessioner Image: constraint of the spectrum o	Seal Intact RELEASED TO: YES NO If NO, Enter remark in Step 5A. / n Device Expiration Date: / (Mo/Day/Yr) SUBSTITUTED INVALID RESULT allyzed, and reported in accordance with applicable federal requirements. / / In/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last)	Seal Intact RELEASED TO: YES NO If NO, Enter remark / in Step 5A. // (Mo/Day/Yr) SUBSTITUTED INVALID RESULT alyzed, and reported in accordance with applicable federal requirements. / / In/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / /	Seal Intact RELEASED TO: YES NO If NO, Enter remark / in Step 5A. // (Mo/Day/Yr) SUBSTITUTED INVALID RESULT alyzed, and reported in accordance with applicable federal requirements. / / In/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / _ /	Seal Intact RELEASED TO: YES NO If NO, Enter remark / in Step 5A. // (Mo/Day/Yr) SUBSTITUTED INVALID RESULT alyzed, and reported in accordance with applicable federal requirements. / / In/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr) Primary/Single Specimen Device Expiration Date: / (Mo/Day/Yr) Split Specime STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY DILUTE REJECTED FOR TESTING DILUTE ODILUTE POSITIVE for: Analyte(s) in ng/mL REMARKS: Test Facility (if different from above) : I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, ana X Signature of Certifying Technician/Scientist Step 5b: COMPLETED BY SPLIT TESTING LABORATORY Laboratory Name RECONFIRMED Laboratory Address Signature of Certifying Scientist	Seal Intact RELEASED TO: YES NO If NO, Enter remark / In Device Expiration Date: / (Mo/Day/Yr) ////////////////////////////////////
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last)	Seal Intact RELEASED TO: YES NO If NO, Enter remark / In Device Expiration Date: / (Mo/Day/Yr) ////////////////////////////////////
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last)	Seal Intact RELEASED TO: YES NO If NO, Enter remark / In Device Expiration Date: / (Mo/Day/Yr) ////////////////////////////////////
X Signature of Accessioner Image: constraint of the system of	Seal Intact RELEASED TO: YES NO If NO, Enter remark / In Device Expiration Date: / (Mo/Day/Yr) ////////////////////////////////////
X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last)	Seal Intact RELEASED TO: YES NO If NO, Enter remark / In Device Expiration Date: / (Mo/Day/Yr) ////////////////////////////////////

Version C 11December2019

SPECIMEN ID NO. 000001 ACCESSION NO.	
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE	
A. Employer Name, Address, I.D. No. B. MRO Name, Address, Phone No. and Fax No.	
C. Donor SSN or Employee I.D. No	r (specify)
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).	
COLLECTION: Split Single None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? Yes No, Enter Remark	Observed, Enter Remark
	ime Indicator(s) Observed
REMARKS:	
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on C STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY	Copy 2 (MRO Copy)
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.	UBE(S) RELEASED TO:
K	
Signature of Collector AM	
PM	
(PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection Name of Delive	ery Service
STEP 5: COMPLETED BY DONOR I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen bottle/tube used was sealed wi in my presence; and that the information provided on this form and on the label affixed to each specimen bottle/tube is correct.	th a tamper-evident seal
X Signature of Donor (PRINT) Donor's Name (First, MI, Last)	/ / Date (Mo/Day/Yr)
Email address: Daytime Phone No. () Evening Phone No. () Date of Birth	ר <u>/ /</u> (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 over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own red 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). – I INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.	about prescriptions and cords. THIS LIST IS NOT
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN	0
In accordance with applicable federal requirements, my verification is: NEGATIVE POSITIVE for: DILUTE DILUTE	
REFUSAL TO TEST because – check reason(s) below: TEST CANC	ELLED
☐ ADULTERATED (adulterant/reason):	
REMARKS:	
X	1 1
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN	Date (Mo/Day/Yr)
In accordance with applicable federal requirements, my verification for the split specimen (if tested) is:	ELLED
FAILED TO RECONFIRM for:	
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Paper CCF: Back of Copy 1:2 Electronic CCF: Separate Page

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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, 5600 Fishers Lane, Room 15E57B, Rockville, Maryland, 20852.

We are moving the Public Burden Statement to be on the back of Copies 1-5 and moving the Privacy Act Statement from the front of Copy 5 to the back of the page.

FE	EDERAL DRUG 1	ESTING CUS	TODY AND CO	NTR	OL FORM
	PECIMEN ID NO.	00000	01 A	CCES	SSION NO.
STEP 1: COMPLETED BY COLLECTOR OF A. Employer Name, Address, I.D. No.	R EMPLOYER REPR	-	3 MRO Name Add	Iress F	Phone No. and Fax No.
		L	5. Millo Humo, 7 du	1000, 1	
C. Donor SSN or Employee I.D. No.					
D. Specify Testing Authority: HHS					FRA 🗌 FTA 🗍 PHMSA 🦳 USCG
E. Reason for Test: Pre-employment Ra	ndom 🗌 Reasonable	Suspicion/Cause] Post Accident	Return	to Duty Follow-up Other (specify)
F. Drug Tests to be Performed: THC, C	COC, PCP, OPI, AMP	THC & COC	Only 🗌 Oth	her (sp	pecify)
G. Collection Site Address:			Collector Conta	ct Info	: Phone
					Fax
					Other
STEP 2: COMPLETED BY COLLECTOR (m	ake remarks when a	appropriate).] ORAL FLUID
COLLECTION: Split Single	None Provided, Enter	Remark.			
· ·		1			s No, Enter Remark Observed, Enter Remark
ORAL FLUID: Split Type: Serial Co	ncurrent 🗌 Subdivi	ded Each Devi	ce Within Expiration	n Date	e? Ves No Volume Indicator(s) Observed
REMARKS:					
	, ,,		• •		or completes STEP 5 on Copy 2 (MRO Copy)
STEP 4: CHAIN OF CUSTODY - INITIATED		_	-		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
I certify that the specimen given to me by the was collected, labeled, sealed and released to the l					
¥	-				
<u>^</u>	Signature of Collector			_	
				AM 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 specimen to the colle in my presence; and that the information provid					ottle/tube used was sealed with a tamper-evident seal be is correct.
X Signature of Donor			(PRINT) Donor's Nam	no (Eirot	i, MI, Last)
	aytime Phone No. ()	Evening Phone No	• •) Date of Birth / /
			Ū		(Mo/Day/Yr)
over-the-counter medications you may ha	ve taken. Therefore st, do so either on a	, you may want to separate piece	o make a list of the of paper or on the	ose me back	she may contact you to ask about prescriptions and edications for your own records. THIS LIST IS NOT of your copy (Copy 5). – DO NOT PROVIDE THIS
	e are adding Steps				
me	oving the Public Bu	rden Statement		e page	e.
Dublic Durdon Statement					
Public Burden Statement	or, and a nerson is n	ot required to req	spond to la collect	tion of	f information unless it displays a currently valid
OMB control number. The OMB control it to average: 5 minutes/donor; 4 minutes/	number for this pro collector; 3 minutes nis collection of info	ject is 0930-0158 /test facility; and rmation, includin	 Public reporting 3 minutes/Medica 	g burc al Rev	den for this collection of information is estimated view Officer. Send comments regarding this ucing this burden, to SAMHSA Reports Clearance

COPY 3 - COLLECTOR COPY

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0000001
SPECIMEN ID NO. 000001 ACCESSION NO.
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE A. Employer Name, Address, I.D. No. B. MRO Name, Address, Phone No. and Fax 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 Specify DOT Agency: FMCSA FAA FAA FAA FAA FAA HSAA 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. Collector Site Address: Collector Contact Info: Phone
Fax Other
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).
COLLECTION: Split Single None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? Yes No, Enter Remark Observed, Enter Remark
ORAL FLUID: Split Type: Serial Concurrent Subdivided Each Device Within Expiration Date? Yes No Volume Indicator(s) Observed REMARKS:
REMARKS. STEP 3: Collector affixes seal(s) to bottle(s)/tube(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.
X
Signature of Collector AM
Image: PM (PRINT) Collector's Name (First, MI, Last) Image: PM Date (Mo/Day/Yr) Time of Collection Name of Delivery Service
STEP 5: COMPLETED BY DONOR
I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen bottle/tube 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/tube is correct.
Signature of Donor (PRINT) Donor's Name (First, MI, Last) / / Date (Mo/Day/Yr) Date (Mo/Day/Yr)
Email address: 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 ÓN THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.
We are adding Steps 6 and 7 from the MRO Copy (Copy 2) here and moving the Public Burden Statement to the back of the page.
moving the rubite Burden Statement to the Busic of the page.
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

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COPY 4 - EMPLOYER COPY

	TESTING CUSTODY AND	CONTR	OL FORM
SPECIMEN ID NO.	0000001	ACCES	SSION NO.
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPR	-		
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:			FRA 🗌 FTA 🗍 PHMSA 🦳 USCG
E. Reason for Test: Pre-employment Random Reasonable	••• – –		
F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP			pecify)
G. Collection Site Address:	Collector C	contact Info	: Phone
			Fax
			Other
STEP 2: COMPLETED BY COLLECTOR (make remarks when a	appropriate).	E [] ORAL FLUID
COLLECTION: Split Single None Provided, Enter	r Remark.		
URINE: Collector reads urine temperature within 4 minutes. Tem	•		—
ORAL FLUID: Split Type: Serial Concurrent Subdiv	rided Each Device Within Expi	iration Date	e? Ves No Volume Indicator(s) Observed
REMARKS:			
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR A		• •	or completes STEP 5 on Copy 2 (MRO Copy)
I certify that the specimen given to me by the donor identified in the			SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
was collected, labeled, sealed and released to the Delivery Service noted in			
Х			
Signature of Collector		AM	
		PM	News of Delivery Derive
(PRINT) Collector's Name (First, MI, Last)	Date (Mo/Day/Yr) Time of Collect	ction	Name of Delivery Service
STEP 5: COMPLETED BY DONOR I certify that I provided my specimen to the collector; that I have not a	adulterated it in any manner; each s	specimen b	ottle/tube used was sealed with a tamper-evident seal
in my presence; and that the information provided on this form and o	on the label affixed to each specime	en bottle/tul	be is correct.
V			
X	(PPINT) Dopor	'e Namo (Firet	
X Signature of Donor	(PRINT) Donor		
Signature of Donor Email address: Daytime Phone No. () Evening Phon	e No. <u>(</u>) Date of Birth / (Mo/Day/Yr)
X Signature of Donor) Evening Phon the specimen identified by this a, you may want to make a list of a separate piece of paper or or	e No. <u>(</u> form, he/s of those m n the back) Date of Birth/ / (Mo/Day/Yr) she may contact you to ask about prescriptions and edications for your own records. THIS LIST IS NOT
Signature of Donor Email address: Daytime Phone No. () Evening Phon the specimen identified by this a separate piece of paper or or THE FORM. TAKE COPY 5 W S Only) ng Custody and Control Form i pr adulteration of a specimen n e federal service or other discip	e No. () Date of Birth / / (Mo/Day/Yr) she may contact you to ask about prescriptions and edications for your own records. THIS LIST IS NOT to f your copy (Copy 5). – DO NOT PROVIDE THIS y. However, incomplete submission of the in delay or denial of your application for On.
Signature of Donor Email address: Daytime Phone No. () Evening Phon the specimen identified by this a separate piece of paper or or THE FORM. TAKE COPY 5 W S Only) ng Custody and Control Form i pr adulteration of a specimen n e federal service or other discip Steps 6 and 7 from the MRO C acy Act Statement and Public bage. Sistance Program, and a super ary to defend against a challenge luntary. Your refusal to furnis pursuant to Executive Order 9 provided for testing. If you refu	e No. () Date of Birth // (Mo/Day/Yr) she may contact you to ask about prescriptions and edications for your own records. THIS LIST IS NOT to f your copy (Copy 5). – DO NOT PROVIDE THIS y. However, incomplete submission of the in delay or denial of your application for on. ("Drug-Free Federal Workplace"), provisions of Executive Order include the agency Medical raumony to take adverse personnel action. This dverse personnel action. mber will not result in the denial of any right, urposes of associating information in agency files

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COPY 5 - DONOR COPY

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