

## FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO.

0000001

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, Employee I.D., or CDL State and No.

D. Specify Testing Authority:  HHS  NRC Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCGE. 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 Contact Info: Phone \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

 URINE ORAL FLUIDCOLLECTION:  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 RemarkORAL FLUID: Split Type:  Serial  Concurrent  Subdivided Each Device Within Expiration Date?  Yes  No  Volume 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 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)/TUBE(S) RELEASED TO:

<b>X</b>	Signature of Collector	AM PM	Name of Delivery Service
(PRINT) Collector's Name (First, MI, Last)	/ /	Date (Mo/Day/Yr)	

## RECEIVED AT LAB OR IITF:

<b>X</b>	Signature of Accessor	Primary Specimen Seal Intact <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, Enter remark in Step 5A.	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
(PRINT) Accessor's Name (First, MI, Last)	/ /	Date (Mo/Day/Yr)	

Primary/Single Specimen Device Expiration Date: / /  
(Mo/Day/Yr)Split Specimen Device Expiration Date: / /  
(Mo/Day/Yr)

## STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY

 NEGATIVE  REJECTED FOR TESTING  ADULTERATED  SUBSTITUTED  INVALID RESULT DILUTE 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, analyzed, and reported in accordance with applicable federal requirements.

<b>X</b>	Signature of Certifying Technician/Scientist	(PRINT) Certifying Technician/Scientist's Name (First, MI, Last)	/ /
			Date (Mo/Day/Yr)

## STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

Laboratory Name	<input type="checkbox"/> RECONFIRMED <input type="checkbox"/> FAILED TO RECONFIRM - REASON _____ I certify that the split specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable federal requirements.
Laboratory Address	<b>X</b> Signature of Certifying Scientist (PRINT) Certifying Scientist's Name (First, MI, Last) / / Date (Mo/Day/Yr)

<b>PLACE OVER CAP</b>	
0000001 SPECIMEN A	/ / Date (Mo/Day/Yr) Donor's Initials
<b>PLACE OVER CAP</b>	
0000001 SPECIMEN B	/ / Date (Mo/Day/Yr) Donor's Initials

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

OMB No. 0930-0158

80303

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B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN, Employee I.D., or CDL State and No.

D. Specify Testing Authority:  HHS  NRC Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCGE. 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 Contact Info: Phone \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

 URINE ORAL FLUIDCOLLECTION:  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 RemarkORAL FLUID: Split Type:  Serial  Concurrent  Subdivided Each Device Within Expiration Date?  Yes  No  Volume 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 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)/TUBE(S) RELEASED TO:

**X**

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 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.***X**

Signature of Donor

(PRINT) Donor's Name (First, MI, Last)

Date (Mo/Day/Yr)

Email address

( ) 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

 URINE  ORAL FLUID*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)

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B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN, Employee I.D., or CDL State and No.

D. Specify Testing Authority:  HHS  NRC Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCGE. 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 Contact Info: Phone \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

 URINE ORAL FLUIDCOLLECTION:  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 RemarkORAL FLUID: Split Type:  Serial  Concurrent  Subdivided Each Device Within Expiration Date?  Yes  No  Volume 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 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)/TUBE(S) RELEASED TO:

<b>X</b>	Signature of Collector	AM	Name of Delivery Service
(PRINT) Collector's Name (First, MI, Last)	/ /	PM	
Date (Mo/Day/Yr)		Time of Collection	

## 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.*

<b>X</b>	Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address	( ) Phone No.	Date of Birth / / (Mo/Day/Yr)	

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## STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

 URINE  ORAL FLUID

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: \_\_\_\_\_

<b>X</b>	Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
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## 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: \_\_\_\_\_

<b>X</b>	Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
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D. Specify Testing Authority:  HHS  NRC Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCGE. 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 Contact Info: Phone \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

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REMARKS: \_\_\_\_\_

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REMARKS: \_\_\_\_\_

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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.

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<b>X</b>	Signature of Collector	AM	Name of Delivery Service
(PRINT) Collector's Name (First, MI, Last)	/ /	PM	
Date (Mo/Day/Yr)		Time of Collection	

## STEP 5: COMPLETED BY DONOR

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<b>X</b>	Signature of Donor	(PRINT) Donor's Name (First, MI, Last)	Date (Mo/Day/Yr)
Email address	( ) Phone No.	Date of Birth	(Mo/Day/Yr)

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## STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

 URINE  ORAL FLUID

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: \_\_\_\_\_

<b>X</b>	Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
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## 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: \_\_\_\_\_

<b>X</b>	Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
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### **Privacy Act Statement: (For Federal Employees Only)**

Submission of the information on the Federal Drug Testing Custody and Control Form is voluntary. However, incomplete submission of the information, refusal to provide a 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 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**

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