



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Minneapolis VAMC Forensic Toxicology Lab 1 Veterans Drive Minneapolis, MN 55417

Forensic Toxicology Drug Testing Laboratory

DONOR 1



Courtesy for Phoenix VA HCS #644 Uneventful collection

SPECIMEN ID NO. 1562101

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. Phoenix VA HCS #649 650 E. Indian School Rd. Phoenix, AZ 85012
B. MRO Name, Address, Phone No. and Fax No. MRO of record P: on record Address on record F: on record
C. Donor SSN, Employee I.D., or CDL State and No. SS#123456789
D. Specify Testing Authority: [X] HHS [ ] NRC Specify DOT Agency: [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG
E. Reason for Test: [X] Pre-employment [ ] Random [ ] Reasonable Suspicion/Cause [ ] Post Accident [ ] Return to Duty [ ] Follow-up [ ] Other (specify)
F. Drug Tests to be Performed: [X] THC, COC, PCP, OPI, AMP [ ] THC & COC Only [ ] Other (specify)
G. Collection Site Address: My VA street My VA City/ST/Zip
Collector Contact Info: Phone Collector's (Service admin phone) Fax Collector's (Service admin fax) Other

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

[X] URINE [ ] ORAL FLUID

COLLECTION: [X] Split [ ] Single [ ] None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? [X] 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:

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 My Name Signature of Collector Today Time AM PM (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: UPS Name of Delivery Service

RECEIVED AT LAB OR IITF: 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 Specimen Device Expiration Date: (Mo/Day/Yr)
Primary Specimen Seal Intact [ ] YES [ ] NO If NO, Enter remark in Step 5A.
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

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.
X 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

[ ] RECONFIRMED [ ] 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.
X Signature of Certifying Scientist (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)



Date (Mo/Day/Yr) Donor's Initials
Date (Mo/Day/Yr) Donor's Initials



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Forensic  
Toxicology  
Drug  
Testing  
Laboratory

DONOR 1

Uneventful  
Courtesy for Phoenix VA

SPECIMEN ID NO. 1562101

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.

CARBON COPIED FROM COPY 1

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  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 Contact Info: Phone

Fax

Other

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

URINE

ORAL FLUID

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:

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

Joe Donor

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

Today  
Date (Mo/Day/Yr)

Email address: IP4U@gmail.com

Daytime Phone No. (111)222 3333

Evening Phone No. (222)333 4444

Date of Birth 1 / 1 / 1980  
(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)



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Minneapolis VAMC Forensic Toxicology Lab 1 Veterans Drive Minneapolis, MN 55417

DONOR 2



Donor refuses to sign CCF

SPECIMEN ID NO. 1562101

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. My VA Name and Station # My VA Street My VA City/ST/Zip
B. MRO Name, Address, Phone No. and Fax No. My Facility MRO P: 111 222 3333 MRO Street F: 111 333 4444 MRO City/ST/Zip
C. Donor SSN, Employee I.D., or CDL State and No. SS# 123456789
D. Specify Testing Authority: [X] HHS [ ] NRC Specify DOT Agency: [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG
E. Reason for Test: [X] Pre-employment [ ] Random [ ] Reasonable Suspicion/Cause [ ] Post Accident [ ] Return to Duty [ ] Follow-up [ ] Other (specify)
F. Drug Tests to be Performed: [X] THC, COC, PCP, OPI, AMP [ ] THC & COC Only [ ] Other (specify)
G. Collection Site Address: My VA street My VA City/ST/Zip
Collector Contact Info: Phone Collector's (service admin phone) Fax Collector's (service admin fax) Other

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

[X] URINE [ ] ORAL FLUID

COLLECTION: [X] Split [ ] Single [ ] None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? [X] 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: Donor refused to sign CCF.

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.
Signature of Collector My Name Today / Time AM PM (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: UPS Name of Delivery Service

RECEIVED AT LAB OR IITF: [X] Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)
Primary Specimen Seal Intact [ ] YES [ ] NO If NO, Enter remark in Step 5A.
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
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 [ ] DILUTE [ ] REJECTED FOR TESTING [ ] ADULTERATED [ ] SUBSTITUTED [ ] INVALID RESULT
[ ] 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.
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

[ ] RECONFIRMED [ ] 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 Name Laboratory Address Signature of Certifying Scientist (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)



Date (Mo/Day/Yr) Donor's Initials Date (Mo/Day/Yr) Donor's Initials



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DONOR 2

Donor refuses to sign CCF

SPECIMEN ID NO. 1562101

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.

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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 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 Contact Info: Phone

Fax

Other

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

URINE

ORAL FLUID

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:

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 "DONOR REFUSED TO SIGN CCF" Signature of Donor

Joe Donor \*Collector writes in donor's name (PRINT) Donor's Name (First, MI, Last)

Today 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 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)

OMB No. 0930-0158



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Minneapolis VAMC Forensic Toxicology Lab 1 Veterans Drive Minneapolis, MN 55417

DONOR 3



Sample is QNS. No 2nd sample produced after 3 hours.

SPECIMEN ID NO. 1562101

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. My VA Name and Station # My VA Street My VA City/ST/Zip
B. MRO Name, Address, Phone No. and Fax No. My Facility MRO P: 111 222 3333 MRO Street F: 111 333 4444 MRO City/ST/Zip
C. Donor SSN, Employee I.D., or CDL State and No. SS# 123456789
D. Specify Testing Authority: [X] HHS [ ] NRC Specify DOT Agency: [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG
E. Reason for Test: [X] Pre-employment [ ] Random [ ] Reasonable Suspicion/Cause [ ] Post Accident [ ] Return to Duty [ ] Follow-up [ ] Other (specify)
F. Drug Tests to be Performed: [X] THC, COC, PCP, OPI, AMP [ ] THC & COC Only [ ] Other (specify)
G. Collection Site Address: My VA street My VA City/ST/Zip
Collector Contact Info: Phone Collector's (svc admin phone) Fax Collector's (svc admin fax) Other

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

[ ] URINE [ ] ORAL FLUID

COLLECTION: [ ] Split [ ] Single [X] 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: Specimen collected was <45ml. Donor unable to produce sufficient quantity after 3 hours. Notified JJ in HR.

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 DO NOT SIGN-- YOU DID NOT RECEIVE A SAMPLE!
Signature of Collector
Nope, nothing here.....or here.....or here either!
(Print) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection PM

LEAVE BLANK!
Name of Delivery Service

RECEIVED AT LAB OR IITF: 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 Specimen Device Expiration Date: (Mo/Day/Yr)
Primary Specimen Seal Intact [ ] YES [ ] NO
If NO, Enter remark in Step 5A.
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

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

[ ] NEGATIVE [ ] DILUTE [ ] REJECTED FOR TESTING [ ] ADULTERATED [ ] SUBSTITUTED [ ] INVALID RESULT
[ ] 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.
X
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

[ ] RECONFIRMED [ ] 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.
X
Laboratory Name
Laboratory Address
Signature of Certifying Scientist (Print) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)



Date (Mo/Day/Yr) Donor's Initials
Date (Mo/Day/Yr) Donor's Initials



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Forensic  
Toxicology  
Drug  
Testing  
Laboratory

**DONOR 3**

SPECIMEN ID NO. **1562101**

**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. \_\_\_\_\_

**CARBON COPIED FROM COPY 1**

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  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 Contact Info: Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
Other \_\_\_\_\_

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

URINE  ORAL FLUID

**CARBON COPIED FROM COPY 1**

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: \_\_\_\_\_

**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.

**CARBON COPIED FROM COPY 1**

**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 **Donor did not provide a sample, does not sign!**

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 \_\_\_\_\_ (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) \_\_\_\_\_

### Insufficient Specimen Form

Donor Name: Branden Lucasta

Date: 1/1/2022

Collector Name: P. Catcher

*In accordance with drug testing standards set forth by federal regulations, the donor has three (3) hours from the time of the first attempt to provide a suitable specimen for testing. During the 3-hour period the donor may drink up to 40 ounces of fluid, but not to exceed 40 ounces, each container of liquid consumed needs to be documented on this form*

Donor Must Remain Inside the Building BL (donor initials)

Drink Up to 40 oz. BL (donor initials)

Provide Valid Specimen Within 3 Hours BL (donor initials)

If You Leave, the Test Will be Considered a Refusal BL (donor initials)

Time of initial attempt to provide a specimen X:XX (time am/pm)

3-hour time limit expires at X:XX + 3hrs (time am/pm)

**Liquids Consumed:**

Cup #1	<u>if needed</u> (fluid amount)	<u>if needed</u> (time am/pm)
Cup #2	<u>"</u> (fluid amount)	<u>"</u> (time am/pm)
Cup #3	<u>"</u> (fluid amount)	<u>"</u> (time am/pm)
Cup #4	<u>"</u> (fluid amount)	<u>"</u> (time am/pm)

**Final result of collection:**

Suitable specimen was obtained at \_\_\_\_\_ (time am/pm)

Three-hour time limit expired, and the Designated Employer Representative (DER) was notified.

H.R. Rep (name of DER)

Donor Signature: Branden Lucasta  
I certify that the above events took place as documented

Collector Signature: \_\_\_\_\_  
I certify that the above events took place as documented

**Collector:** This form should be retained as documentation of the events that took place.



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Minneapolis VAMC Forensic Toxicology Lab 1 Veterans Drive Minneapolis, MN 55417

DONOR 4A



Temperature OOR

SPECIMEN ID NO. 1562101

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. My VA Name and Station # My VA Street My VA City/ST/Zip
B. MRO Name, Address, Phone No. and Fax No. My Facility MRO P: 111 222 3333 MRO Street F: 111 333 4444 MRO City/ST/Zip
C. Donor SSN, Employee I.D., or CDL State and No. SS# 123456789
D. Specify Testing Authority: [X] HHS [ ] NRC Specify DOT Agency: [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG
E. Reason for Test: [X] Pre-employment [ ] Random [ ] Reasonable Suspicion/Cause [ ] Post Accident [ ] Return to Duty [ ] Follow-up [ ] Other (specify)
F. Drug Tests to be Performed: [X] THC, COC, PCP, OPI, AMP [ ] THC & COC Only [ ] Other (specify)
G. Collection Site Address: My VA street My VA City/ST/Zip
Collector Contact Info: Phone Collector's (svc admin phone) Fax Collector's (svc admin fax) Other

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

[X] URINE [ ] ORAL FLUID

COLLECTION: [X] Split [ ] Single [ ] None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? [ ] Yes [X] 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: Temp OOR, 2nd specimen collected under DO on #1562102. Spec.#1 of 2.

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.
Signature of Collector: My Name Today / Time AM PM
(Print) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: UPS
Name of Delivery Service

RECEIVED AT LAB OR IITF: [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 Specimen Device Expiration Date: / / (Mo/Day/Yr)
Primary Specimen Seal Intact: [ ] YES [ ] NO
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY
[ ] NEGATIVE [ ] DILUTE [ ] REJECTED FOR TESTING [ ] ADULTERATED [ ] SUBSTITUTED [ ] INVALID RESULT
[ ] 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.
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: Laboratory Address:
[ ] RECONFIRMED [ ] 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.
Signature of Certifying Scientist: (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)



Date (Mo/Day/Yr) Donor's Initials Date (Mo/Day/Yr) Donor's Initials



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Forensic  
Toxicology  
Drug  
Testing  
Laboratory

DONOR 4A

SPECIMEN ID NO.

1562101

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.

CARBON COPIED FROM COPY 1

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  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 Contact Info: Phone

Fax

Other

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

URINE

ORAL FLUID

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:

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

Joe Donor

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

Today /  
Date (Mo/Day/Yr)

Email address: IP4U@gmail.com Daytime Phone No. (111) 222 3333 Evening Phone No. (222) 333 4444 Date of Birth 1 / 1 / 1980 (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)



Forensic  
Toxicology  
Drug  
Testing  
Laboratory

DONOR 4B



1st Sample was temp OOR

SPECIMEN ID NO. 1562102

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. **My VA Name and Station #**  
**My VA Street**  
**My VA City/ST/Zip**

B. MRO Name, Address, Phone No. and Fax No.  
**My Facility MRO P: 111 222 3333**  
**MRO Street F: 111 333 4444**  
**MRO City/ST/Zip**

C. Donor SSN, Employee I.D., or CDL State and No. **SS#123456789**

D. Specify Testing Authority:  HHS  NRC 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: **My VA street**  
**My VA City/ST/Zip**

Collector Contact info: Phone **Collector's (svc admin phone)**  
Fax **Collector's (svc admin fax)**  
Other \_\_\_\_\_

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

URINE  ORAL FLUID

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: **Specimen 2 of 2. Specimen 1 on #1562101 was "temp oor" \*Name of observer if not the same as collector\***

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 My Name**  
Signature of Collector

**My Name Today / Time AM PM**  
(Print) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:  
**UPS**  
Name of Delivery Service

RECEIVED AT LAB OR IITF:  
**X**  
Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)

Primary Specimen Seal Intact  
 YES  NO  
If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

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  DILUTE  REJECTED FOR TESTING  ADULTERATED  SUBSTITUTED  INVALID RESULT

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.

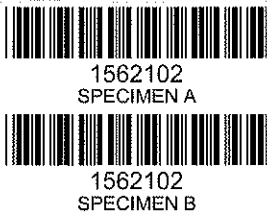
**X**  
Signature of Certifying Technician/Scientist (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

RECONFIRMED  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.

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



Date (Mo/Day/Yr)  
Donor's Initials  
Date (Mo/Day/Yr)  
Donor's Initials





Forensic  
Toxicology  
Drug  
Testing  
Laboratory

**DONOR 4B**

SPECIMEN ID NO. **1562102**

**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.

**CARBON COPIED FROM COPY 1**

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  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 Contact Info: Phone \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

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

URINE  ORAL FLUID

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:

**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 Joe Donor  
Signature of Donor

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

Today /  
Date (Mo/Day/Yr)

Email address: IP4U@pmail.com Daytime Phone No. (111) 222 3333 Evening Phone No. (222 333 4444) Date of Birth 1 / 1 / 1980  
(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)

COPY 2 - MEDICAL REVIEW OFFICER COPY



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Minneapolis VAMC Forensic Toxicology Lab 1 Veterans Drive Minneapolis, MN 55417

DONOR 5



Donor refused to sign bottle seals

SPECIMEN ID NO. 1562101

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

ACCESSION NO.

A. Employer Name, Address, I.D. No. My VA Name and Station # My VA Street My VA City/ST/Zip
B. MRO Name, Address, Phone No. and Fax No. My Facility MRO P: 111 222 3333 MRO Street F: 111 333 4444 MRO City/ST/Zip
C. Donor SSN, Employee I.D., or CDL State and No. SS# 123456789
D. Specify Testing Authority: [X] HHS [ ] NRC Specify DOT Agency: [ ] FMCSA [ ] FAA [ ] FRA [ ] FTA [ ] PHMSA [ ] USCG
E. Reason for Test: [X] Pre-employment [ ] Random [ ] Reasonable Suspicion/Cause [ ] Post Accident [ ] Return to Duty [ ] Follow-up [ ] Other (specify)
F. Drug Tests to be Performed: [X] THC, COC, PCP, OPI, AMP [ ] THC & COC Only [ ] Other (specify)
G. Collection Site Address: My VA street My VA City/ST/Zip
Collector Contact Info: Phone Collector's (svc admin phone) Fax Collector's (svc admin fax) Other

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

[X] URINE [ ] ORAL FLUID

COLLECTION: [X] Split [ ] Single [ ] None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? [X] 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: Donor refused to initial bottle seals.

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.
Signature of Collector: My Name Today, Time AM/PM
Name of Delivery Service: UPS

RECEIVED AT LAB OR IITF:

Signature of Accessioner: My Name Date (Mo/Day/Yr) Time of Collection
Primary Specimen Seal Intact: [ ] YES [ ] NO
SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
Primary/Single Specimen Device Expiration Date: Split Specimen Device Expiration Date:

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

[ ] NEGATIVE [ ] DILUTE [ ] REJECTED FOR TESTING [ ] ADULTERATED [ ] SUBSTITUTED [ ] INVALID RESULT
[ ] 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.
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

[ ] RECONFIRMED [ ] 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.
Signature of Certifying Scientist: (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)



Date (Mo/Day/Yr) Donor's Initials



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Forensic  
Toxicology  
Drug  
Testing  
Laboratory

**DONOR 5**

SPECIMEN ID NO. **1562101**

**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.

**CARBON COPIED FROM COPY 1**

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  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 Contact Info: Phone

Fax

Other

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

URINE

ORAL FLUID

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:

**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

Joe Donor

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

Today

Date (Mo/Day/Yr)

Email address: **IP4U@gmail.com** Daytime Phone No. **(111) 222 3333** Evening Phone No. **(222) 333 4444** Date of Birth **1 / 1 / 1980**  
(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)