

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: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG	
E. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____	
F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> 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: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

<p><i>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.</i></p> <p>X _____ Signature of Collector</p> <p>_____/_____/_____ (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection AM PM</p>	<p>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</p> <p>_____ Name of Delivery Service</p>
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<p>RECEIVED AT LAB OR IITF:</p> <p>X _____ Signature of Accessioner</p> <p>_____/_____/_____ (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)</p>	<p>Primary Specimen Seal Intact</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If NO, Enter remark in Step 5A.</p>	<p>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</p>
<p>Primary/Single Specimen Device Expiration Date: ____/____/_____ (Mo/Day/Yr)</p>	<p>Split Specimen Device Expiration Date: ____/____/_____ (Mo/Day/Yr)</p>	

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

<input type="checkbox"/> NEGATIVE <input type="checkbox"/> REJECTED FOR TESTING <input type="checkbox"/> ADULTERATED <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> INVALID RESULT <input type="checkbox"/> DILUTE <input type="checkbox"/> POSITIVE for: _____ <i>Analyte(s) in ng/mL</i>
REMARKS: _____ Test Facility (if different from above): _____ <i>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.</i>
<p>X _____ Signature of Certifying Technician/Scientist</p> <p>_____/_____/_____ (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)</p>

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

Laboratory Name _____ Laboratory Address _____	<input type="checkbox"/> RECONFIRMED <input type="checkbox"/> FAILED TO RECONFIRM - REASON _____ <i>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.</i>
<p>X _____ Signature of Certifying Scientist</p> <p>_____/_____/_____ (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)</p>	

<p>0000001 SPECIMEN A</p>	_____/_____/_____ Date (Mo/Day/Yr) _____ Donor's Initials	<p>0000001 SPECIMEN B</p>	_____/_____/_____ Date (Mo/Day/Yr) _____ Donor's Initials
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OMB No. 0930-0158

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

Version C 8May2020

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FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

ACCESSION NO.

OMB No. 0930-0158

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 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.

X _____
 Signature of Collector

_____ AM
 _____ PM

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

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

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

ACCESSION NO.

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. C. Donor SSN, Employee I.D., or CDL State and No. D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG E. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____ F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ G. Collection Site Address: _____	B. MRO Name, Address, Phone No. and Fax No. Collector Contact Info: Phone _____ Fax _____ Other _____
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STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). URINE ORAL FLUID

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 _____ Signature of Collector _____ / ____ / ____ AM (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: _____ Name of Delivery Service
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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 _____ (PRINT) Donor's Name (First, MI, Last) _____ / ____ / ____
 Signature of Donor 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 _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____ / ____ / ____
 Signature of Medical Review Officer 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 _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____ / ____ / ____
 Signature of Medical Review Officer Date (Mo/Day/Yr)

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

ACCESSION NO.

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. C. Donor SSN, Employee I.D., or CDL State and No. D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG E. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____ F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ G. Collection Site Address: _____	B. MRO Name, Address, Phone No. and Fax No. Collector Contact Info: Phone _____ Fax _____ Other _____
--	--

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

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark. URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

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

Email address: _____ Daytime Phone No. () _____ Evening 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: _____

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

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.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

ACCESSION NO.

OMB No. 0930-0158

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A. Employer Name, Address, I.D. No. C. Donor SSN, Employee I.D., or CDL State and No. D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG E. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____ F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ G. Collection Site Address: _____	B. MRO Name, Address, Phone No. and Fax No. Collector Contact Info: Phone _____ Fax _____ Other _____
--	--

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

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 _____ Signature of Collector _____ / ____ / ____ AM (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: _____ Name of Delivery Service
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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: _____ 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)

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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