	D CONTROL F	ORM	
SPECIMEN ID NO. 000001	ACCESSION	NO.	
A. Employer Name, Address, I.D. No. B. MRO Name	ne, 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	□ FTA □ PHMSA □	
E. Reason for Test: Pre-employment Random Reasonable Suspicion/Cause Post Accide			_
G. Collector Site Address: Collector		ne ах	
		er	
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 ORAL FLUID: Split Type: Serial Concurrent Subdivided Each Device Within Ex			dicator(s) Observed
REMARKS:			2 (MRO Copy)
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials	seal(s). Donor con	npletes STEP 5 on Copy 2	2 (MRO Copy)
STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FA			S) RELEASED TO:
I certify that the specimen given to me by the donor identified in the certification section on Copy 2 o was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable federal		CIMEN BOTTLE(S)/TUBE(S) RELEASED TO:
X			
Signature of Collector	AM		
(PRINT) Collector's Name (First, MI, Last)	PM	Name of Delivery Serv	
RECEIVED AT LAB OR IITF:	Primary S	Specimen SPECIMEN BC	DTTLE(S)/TUBE(S)
X Signature of Accessioner	Seal		ASED TO:
	/ If NO, Ente	er remark	
			1
(PRINT) Accessioner's Name (First, MI, Last) Primary/Single Specimen Device Expiration Date: / / Split S	. ,	oiration Date: /	Yr)
	provide the section of the section o	piration Date: / (Mo/Day/۱	
Primary/Single Specimen Device Expiration Date: / / / Split S (Mo/Day/Yr) STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY	Specimen Device Ex	(Mo/Day/	
Primary/Single Specimen Device Expiration Date: / / Split S (Mo/Day/Yr)	Juday/11)	(Mo/Day/	ALID RESULT
Primary/Single Specimen Device Expiration Date: / / / Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY Image: Complete Co	Specimen Device Ex	(Mo/Day/	ALID RESULT
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTER ADULTER POSITIVE for: Analyte(s) in ng/mL REMARKS: Image: Complex co	Specimen Device Ex	(Mo/Day/	ALID RESULT
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTE ADULTE Analyte(s) in ng/mL Negarive Negarive	Specimen Device Ex	ITUTED [] INV	
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTERATED ADULTERATED Image: Distribute for: Analyte(s) in ng/mL REMARKS: Image: Distribute for: Test Facility (if different from above) : Image: Distribute for: Image: Distribute for: Image: Distribute for: Image: Complexity for the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on this form was examined upon receipt, handled using chain of custody procedute the specime identified on the specime identident identified identified on the specime ident	Specimen Device Ex	ITUTED INV	blefederal requirements.
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE POSITIVE for: Analyte(s) in ng/mL 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 procedu X	Specimen Device Ex	ITUTED INV	
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE POSITIVE for: Analyte(s) in ng/mL Analyte(s) in ng/mL REMARKS: Test Facility (if different from above) : Icertify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedu X	Jures, analyzed, and rep	ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr)
Primary/Single Specimen Device Expiration Date: / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTERATED ADULTERATED POSITIVE for:	Specimen Device Ex Specimen Device Ex SUBST Jures, analyzed, and rep Technician/Scientist's Na REASON	ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr)
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTERATED ADULTERATED POSITIVE for: Analyte(s) in ng/mL REMARKS: Image: Complete Completer Complet	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	(Mo/Day/ ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr) of custody procedures, / /
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY REJECTED FOR TESTING ADULTERATED DILUTE DILUTE ADULTERATED ADULTERATED POSITIVE for: Analyte(s) in ng/mL REMARKS: Image: Complete Completer Complete Completer Complete Completer Completer Complete Complete Complete Complete Compl	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr)
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S Step 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY ADULTE ADULTERATED DILUTE POSITIVE for: Analyte(s) in ng/mL 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 proceded X Signature of Certifying Technician/Scientist (PRINT) Certifying T STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY I certify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal A Laboratory Name I certify ing Certifying Scientist Y Laboratory Address I optic (Mc/Deu/Kr) PLACE	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	(Mo/Day/ ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr) of custody procedures, / /
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY ADULTERATED ADULTERATED DILUTE REJECTED FOR TESTING ADULTERATED POSITIVE for: Analyte(s) in ng/mL Analyte(s) in ng/mL REMARKS: Test Facility (if different from above) : Icertify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedu X Signature of Certifying Technician/Scientist (PRINT) Certifying Technician/Scientist STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY Icertify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal Alignment of Certifying Scientist Laboratory Address Signature of Certifying Scientist Image: Complex compl	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	(Mo/Day/ ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr) of custody procedures, / /
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY Adulterated Adulterated DILUTE REJECTED FOR TESTING Adulterated DILUTE DILUTE Analyte(s) in ng/mL Analyte(s) in ng/mL REMARKS: Test Facility (if different from above) : Icertify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedu X Signature of Certifying Technician/Scientist (PRINT) Certifying T STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY Icertify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal X Signature of Certifying Scientist Icertify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal Laboratory Name Icertify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal X Signature of Certifying Scientist Signature of Certifying Scientist Image: Specimen A Donor's Initials OVER	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	(Mo/Day/ ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr) of custody procedures, / /
Primary/Single Specimen Device Expiration Date: / / / (Mo/Day/Yr) Split S STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY ADULTERATED ADULTERATED DILUTE REJECTED FOR TESTING ADULTERATED POSITIVE for: Analyte(s) in ng/mL 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 procedu X Signature of Certifying Technician/Scientist (PRINT) Certifying Technician/Scientist STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY I certify that the split specimen identified on this form analyzed, and reported in accordance with applicable federal X Laboratory Address Signature of Certifying Scientist Image: Complex Com	Specimen Device Ex Specimen Device Ex SUBST dures, analyzed, and rep Technician/Scientist's Na REASON	(Mo/Day/ ITUTED INV	blefederal requirements. / / Date (Mo/Day/Yr) of custody procedures, / /

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	FEDERAL DRUG	TESTING CUSTODY AN	D CONTROL	FORM
	SPECIMEN ID NO.	0000001	ACCESSIC	DN NO.
STEP 1: COMPLETED BY COLLE				
A. Employer Name, Address, I.D. N	No.	B. MRO Nam	ne, Address, Pho	ne No. and Fax No.
C. Donor SSN, Employee I.D., or (D. Specify Testing Authority: E. Reason for Test: Pre-employm F. Drug Tests to be Performed: G. Collection Site Address:	HHS	Suspicion/Cause Post Accide	ent	A FTA PHMSA USCG Duty Follow-up Other (specify) fy hone Fax Duty Duty Fax
STEP 2: COMPLETED BY COLLE	ECTOR (make remarks when	appropriate).		ORAL FLUID
URINE: Collector reads urine ten	•	emperature between 90° and 10		No, Enter Remark Observed, Enter Rema
ORAL FLUID: Split Type: Ser	ial 🗌 Concurrent 🔲 Subdiv	vided Each Device Within Ex		Yes No Volume Indicator(s) Observ
				completes STEP 5 on Copy 2 (MRO Copy)
I certify that the specimen given to was collected, labeled, sealed and relea				PECIMEN BOTTLE(S)/TUBE(S) RELEASED T
X	Signature of Collector		AM	
		/ /	PM	Name of Delivery Service
(PRINT) Collector's Na		Date (Mo/Day/Yr) Time of Co	llection	Name of Delivery Service
	to the collector; that I have not			/tube used was sealed with a tamper-evident seal s correct.
Signature o		. ,	nor's Name (First, MI, I	, , , ,
Email address:	Daytime Phone No. () Evening Pho	one No. <u>(</u>)	Date of Birth/ /(Mo/Day/Yr)
over-the-counter medications yo	ou may have taken. Therefore make a list, do so either on a	e, you may want to make a lis a separate piece of paper or	t of those medic on the back of	may contact you to ask about prescriptions a cations for your own records. THIS LIST IS N your copy (Copy 5). – DO NOT PROVIDE T
STEP 6: COMPLETED BY MEDIC In accordance with applicable federa	-	-		
NEGATIVE POSITIVE	for:			
	erant/reason):			
REMARKS:				
X				
Signature of Media STEP 7: COMPLETED BY MEDIC In accordance with applicable federa		IT SPECIMEN	Review Officer's Name	e (First, MI, Last) Date (Mo/Day/Yr)
				TEST CANCELLED
	for			
FAILED TO RECONFIRM				
FAILED TO RECONFIRM				
				, , ,

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	FEDERAL DRUG	TESTING CUST	ODY AND CO	ONTRO	L FOR	RM	
	SPECIMEN ID NO.	000000)1	ACCESS	SION NO		
A. Employer Name, Address, I.D. No		-	MRO Name, Ad	Idroce Dr	nono No	and Eax No	
A. Employer Name, Address, I.D. No		D.	MRO Name, Au	iuless, Fi	Ione No.	. anu fax nu.	
C. Donor SSN, Employee I.D., or CI D. Specify Testing Authority: H E. Reason for Test: Pre-employmer F. Drug Tests to be Performed: G. Collection Site Address:	HS ☐ NRC Specify nt ☐ Random ☐ Reasonable	e Suspicion/Cause 🗌 I	Post Accident] Return to Other (spe	Duty C cify) Phone _ Fax _		ý)
	TOP (make remarks when	appropriato)				_ FLUID	
COLLECTION: Split Sing	•	,					
DRAL FLUID: Split Type: Seria REMARKS:	bottle(s)/tube(s). Collector TIATED BY COLLECTOR A e by the donor identified in th	or dates seal(s). Don AND COMPLETED B	Y TEST FACILI n Copy 2 of this	(s). Dono TY	r compl		
vas collected, labeled, sealed and releas							
(Signature of Collector			AM			
(PRINT) Collector's Name	e (First, MI, Last)	/ / Date (Mo/Day/Yr)	Time of Collection	PM		Name of Delivery Service	9
certify that I provided my specimen to m my presence; and that the informat Signature of D Email address:	ion provided on this form and onor Daytime Phone No. (receives the test results for may have taken. Therefor	on the label affixed to o	(PRINT) Donor's Na vening Phone N ified by this for nake a list of th	ame (First, M lo. () m, he/sh	is correc II, Last) e may c dications	ct. Date of Birth contact you to ask about s for your own records. T	/ Date (Mo/Day/Yr) / (Mo/Day/Yr) prescriptions ar FHIS LIST IS NC
NECESSARY. If you choose to m NFORMATION ON THE BACK C	ake a list, do so either on OF ANY OTHER COPY OF	a separate piece of THE FORM. TAKE	paper or on th COPY 5 WITH	ne back c I YOU.	of your c	copy (Copy 5). – DO NO	T PROVIDE TH
TEP 6: COMPLETED BY MEDICA n accordance with applicable federal			[ORAL FLUID	
NEGATIVE DILUTE DILUTE REFUSAL TO TEST because – c ADULTERATED (adulters SUBSTITUTED	r: heck reason(s) below: ant/reason):)
Signature of Medica STEP 7: COMPLETED BY MEDICA In accordance with applicable federal	L REVIEW OFFICER - SPL	IT SPECIMEN	IT) Medical Review (Officer's Na	me (First, I	MI, Last)	/ / Date (Mo/Day/Yr)
RECONFIRMED for: FAILED TO RECONFIRM fo REMARKS:	r:		,)
X							
Signature of Medica			TOR COPY	Officer's Na	me (First, I	MI, Last)	Date (Mo/Day/Yr)

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	FEDERAL DRUG	TESTING CUST	FODY AND CO	NTRO	DL FORM	
		00000	01			
STEP 1: COMPLETED BY COLLE	SPECIMEN ID NO. CTOR OR EMPLOYER REPI			CCES	SION NO.	
A. Employer Name, Address, I.D. N			8. MRO Name, Add	lress, P	hone No. and Fax No.	
C. Donor SSN, Employee I.D., or C	DL State and No					
D. Specify Testing Authority: E. Reason for Test: Pre-employme	HS 🗌 NRC Specify	••••			FRA FTA PHMSA FINDER FOLLOW-UP OTHER (spe	
F. Drug Tests to be Performed:] THC, COC, PCP, OPI, AMI	P THC & COC			ecify)	
G. Collection Site Address:			Collector Conta	ct Info:	Phone Fax	
					Other	
STEP 2: COMPLETED BY COLLE	CTOR (make remarks when	appropriate).] ORAL FLUID	
COLLECTION: 🗌 Split 🗌 Sin						
URINE: Collector reads urine tem		•				erved, Enter Remarl
DRAL FLUID: Split Type: ☐ Seria REMARKS:	al 🗌 Concurrent 🔲 Subdiv		ce Within Expiration	n Date :		ndicator(s) Observe
TEP 3: Collector affixes seal(s) t TEP 4: CHAIN OF CUSTODY - IN	., .,				or completes STEP 5 on Copy	2 (MRO Copy)
certify that the specimen given to n vas collected, labeled, sealed and release	ne by the donor identified in th	e certification section	on Copy 2 of this i	form	SPECIMEN BOTTLE(S)/TUBE	(S) RELEASED TO
				memo.		
(Signature of Collector			-		
				AM PM		
(PRINT) Collector's Nam	e (First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection		Name of Delivery Ser	vice
TEP 5: COMPLETED BY DONOR certify that I provided my specimen to my presence; and that the informa	to the collector; that I have not					amper-evident seal
Signature of			(PRINT) Donor's Nan	•		Date (Mo/Day/Yr)
Email address:	Daytime Phone No. () E	Evening Phone No	. ()	Date of Birth	/ / (Mo/Day/Yr)
After the Medical Review Officer over-the-counter medications you NECESSARY. If you choose to m NFORMATION ON THE BACK (u may have taken. Therefore nake a list. do so either on a	e, you may want to a separate piece o	make a list of the	ose me e back (dications for your own records	3. THIS LIST IS NO
TEP 6: COMPLETED BY MEDICA in accordance with applicable federal				URI	NE ORAL FLUID	
NEGATIVE POSITIVE for	or:					
DILUTE DILUTE	check reason(s) below:					FD
	rant/reason):					
X						1 1
Signature of Medica	AL REVIEW OFFICER - SPL	IT SPECIMEN	INT) Medical Review Of	fficer's Na	ame (First, MI, Last)	Date (Mo/Day/Yr)
n accordance with applicable federal		, ,	, ,		TEST CANCELL	ED
FAILED TO RECONFIRM for						
REMARKS:						
Signature of Medica	al Review Officer		INT) Medical Review Of	fficer's M	ame (First MI Last)	/ / Date (Mo/Day/Yr)
Signature of Medica		COPY 4 - FMPI (nicer S Na	unio (1 1131, 111, Ed31)	

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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.

	FEDERAL DRUG	TESTING CUS	TODY AND CC	ONTRO	OL FORM	
		00000	01			
TEP 1: COMPLETED BY COLLEC	SPECIMEN ID NO. TOR OR EMPLOYER REPI			ACCES	SION NO.	
A. Employer Name, Address, I.D. No			3. MRO Name, Ado	dress, F	Phone No. and Fax No.	
C. Donor SSN, Employee I.D., or CI	DL State and No.					
D. Specify Testing Authority: H E. Reason for Test: Pre-employme	nt 🗌 Random 🗌 Reasonable	e Suspicion/Cause]Post Accident	Return t		(specify)
Drug Tests to be Performed: G. Collection Site Address:] THC, COC, PCP, OPI, AM	P _ THC & COC			ecify)	
5. Collection Oile Address.			Collector Conta	act into:	Phone Fax	
					Other	
TEP 2: COMPLETED BY COLLEC	TOR (make remarks wher	ı appropriate).] ORAL FLUID	
COLLECTION: 🗌 Split 🗌 Sing	gle 🔲 None Provided, Ente	er Remark.				
JRINE: Collector reads urine temp		•		_		
DRALFLUID: Split Type: Seria	I 🗌 Concurrent 🗌 Subdi	vided Each Devi	ce Within Expiratio	on Date	? Yes No Volu	me Indicator(s) Observe
REMARKS:	- k - 441- (-) (4-1k - (-) 0- 114					
TEP 3: Collector affixes seal(s) to TEP 4: CHAIN OF CUSTODY - IN					or completes STEP 5 on C	opy 2 (MRO Copy)
certify that the specimen given to m				1	SPECIMEN BOTTLE(S)/T	UBE(S) RELEASED TO
vas collected, labeled, sealed and releas						
	Signature of Collector			AM		
		/		PM		
(PRINT) Collector's Name) (First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection		Name of Delive	ry Service
CETEP 5: COMPLETED BY DONOR certify that I provided my specimen to n my presence; and that the informat						h a tamper-evident seal
X Signature of E	Jonor		(PRINT) Donor's Nar	ma (Eirat	MLLoot	/ / Date (Mo/Day/Yr)
Email address:		()	. ,	•) Date of Birth	
			-			(Mo/Day/Yr)
After the Medical Review Officer i over-the-counter medications you NECESSARY. If you choose to m NFORMATION ON THE BACK C	ı may have taken. Therefor ake a list. do so either on	e, you may want to a separate piece	make a list of the	ose me e back	dications for your own rec	ords. THIS LIST IS NO
TEP 6: COMPLETED BY MEDICA					NE 🗌 ORAL FLUID)
n accordance with applicable federal I NEGATIVE I POSITIVE fo DILUTE	requirements, my verification pr:	IS:				
	()					ELLED
	ant/reason):					
REMARKS:						
X Signature of Medica	Review Officer	(PF	NNT) Medical Review O	fficer's N	ame (First, MI, Last)	/ // Date (Mo/Day/Yr)
TEP 7: COMPLETED BY MEDICA	L REVIEW OFFICER - SPL	IT SPECIMEN	· ·			Date (morbay, 11)
n accordance with applicable federal			/			
REMARKS:						
v						
X Signature of Medica	I Review Officer	(PF	NNT) Medical Review O	fficer's N	ame (First, MI, Last)	/ / Date (Mo/Day/Yr)
		COPY 5 - DON			<u> </u>	

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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

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.