

SPECIMEN ID NO.

Version C 14May2010

000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESEN	TATIVE	ACCESSIO	
A. Employer Name, Address, I.D. No.	B. MRO Name, Addr	ess, Phone No. and Fa	OMB No. 0930-0158
C. Donor SSN or Employee I.D. No.			
E. Reason for Test: Pre-employment Random Reasonable Suspicion		n to Duty	Other (specify)
F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP G. Collection Site Address:	☐ THC & COC Only ☐ Othe	er (specify)	
STEP 2: COMPLETED BY COLLECTOR (make remarks when appro		ollector Fax No	n / minutes
	ollection: Split Single		
REMARKS			77.7
STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND CO		Donor completes STI	
I certify that the specimen given to me by the donor identified in the certification collected, labeled, sealed and released to the Delivery Service noted in accordance	n section on Copy 2 of this form wa		N BOTTLE(S) RELEASED TO:
X Signature of Collector		_	
Signature of Collector	/ AN		
	(Mo/Day/Yr) Time of Collection		Name of Delivery Service
RECEIVED AT LAB OR IITF:		Primary Specimen Bottle Seal Intact	SPECIMEN BOTTLE(S) RELEASED TO:
Signature of Accessioner		YES NO	
(DDINE)		If NO, Enter remark	
(PRINT) Accessioner's Name (First, MI, Last) STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST F.	Date (Mo/Day/Yr)	in Step 5A.	
NEGATIVE POSITIVE for: Marijuana Metabolite (9-THCA Cocaine Metabolite (BZE) □ DILUTE □ Cocaine Metabolite (BZE) □ PCP □ REJECTED FOR TESTING □ ADULTERATED □ SUE REMARKS: □ SUE		MDA Mor	Name of Delivery Service SPECIMEN BOTTLE(S) RELEASED TO: morphine OXYC HYC ohine OXYM HYM Codeine
Test Facility (if different from above) :	using chain of custody procedures, anal	yzed, and reported in accor	
Χ			
Signature of Certifying Technician/Scientist	(PRINT) Certifying Technician/S	cientist's Name (First, MI, La	ast) Date (Mo/Day/Yr)
STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY			
I certify that the split speci	FAILED TO RECONFIRM - REASO men identified on this form was examine with applicable Federal requirements.		sing chain of custody procedures, analyzed,
Laboratory Address Signature of Cert	ifying Scientist (PRINT)	Certifying Scientist's Name (I	First, MI, Last) Date (Mo/Day/Yr)
0000001 SPECIMEN ID NO.	PLACE OVER CAP	0000001 PECIMEN BOTTL SEAL	Date (Mo/Day/Yr) Donor's Initials
0000001 (SPLIT) SPECIMEN ID NO.	PLACE OVER CAP	0000001 PECIMEN BOTTL SEAL	Date (Mo/Day/Yr) Donor's Initials

SPECIMEN ID NO. 000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER	REPRESENTATIVE	ACCESSION NO.
A. Employer Name, Address, I.D. No.	B. MRO Name, Addres	s, Phone No. and Fax No.
C. Donor SSN or Employee I.D. No		
	pecify DOT Agency: FMCSA FAA	 □ FRA □ FTA □ PHMSA □ USCG
E. Reason for Test: Pre-employment Random Reason		
		(specify)
G. Collection Site Address:		
	Coll	ector Phone No
	Coll	ector Fax No
STEP 2: COMPLETED BY COLLECTOR (make remarks v		
Temperature between 90° and 100° F? Yes No, Enter Re	mark Collection: Split Single	None Provided, Enter Remark
REMARKS		
STEP 3: Collector affixes bottle seal(s) to bottle(s). Colle STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTO		nor completes STEP 5 on Copy 2 (MRO Copy)
I certify that the specimen given to me by the donor identified in t	the certification section on Copy 2 of this form was	SPECIMEN BOTTLE(S) RELEASED TO:
collected, labeled, sealed and released to the Delivery Service noted	i in accordance with applicable Federal requirements.	
X Signature of Collect	tor	
Organical of Contact	/ / / 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 urine specimen to the collector; that	I I be a second and the second and t	- Constitution of the state of
my presence; and that the information provided on this form an	(PRINT) Donor's Name (F	
Daytime Phone No. ()	Evening Phone No()	Date of Birth/(Mo/Day/Yr)
After the Medical Review Officer receives the test resultover-the-counter medications you may have taken. The NECESSARY. If you choose to make a list, do so eithe INFORMATION ON THE BACK OF ANY OTHER COP	refore, you may want to make a list of those or on a separate piece of paper or on the bay OF THE FORM. TAKE COPY 5 WITH YO	e/she may contact you to ask about prescriptions medications for your own records. THIS LIST IS ack of your copy (Copy 5). – DO NOT PROVIDE
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - In accordance with applicable Federal requirements, my verific		
□ NEGATIVE □ POSITIVE for:		
DILUTE		
☐ REFUSAL TO TEST because – check reason(s) below: ☐ ADULTERATED (adulterant/reason):		TEST CANCELLED
SUBSTITUTED		
REMARKS:		
1.2.00		
Signature of Medical Review Officer	(PRINT) Medical Review Office	r's Name (First, MI, Last) Jate (Mo/Day/Yr)
STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER -	SPLIT SPECIMEN	
In accordance with applicable Federal requirements, my verific	cation for the split specimen (if tested) is:	
RECONFIRMED for:		TEST CANCELLED
FAILED TO RECONFIRM for:		
REMARKS:		
X Clearly AM-H-12 1 20	(DDIAIT) II I D I D I	who Marrier (First MI Lock)
Signature of Medical Review Officer	(PRINT) Medical Review Office	r's Name (First, MI, Last) Date (Mo/Day/Yr)

PECIMEN ID NO. 000001

. Employer Name, Address, I.D. I	NI -	REPRESENTATIVE	D MDO Name Ad	ACCESSION NO	
	No.		B. MRO Name, Ad	Idress, Phone No. and Fax No).
. Donor SSN or Employee I.D. N	lo.				
. Specify Testing Authority:				A FRA FTA	PHMSA USCG
. Reason for Test: Pre-employn					
Drug Tests to be Performed:	☐ THC, COC, PCP, OP!	I, AMP	COC Only	ther (specify)	
. Collection Site Address:					
				Collector Phone No	
				Collector Fax No	
TEP 2: COMPLETED BY COLLI	ECTOR (make remarks v	when appropriate) C			ninutes.
emperature between 90° and 100° F?	Yes No, Enter Rer		Split Single		
EMARKS					
TEP 3: Collector affixes bottle	seal(s) to hottle(s). Colle	ector dates seal(s) [Onnor initials seal(s) Donor completes STEP 5	on Cony 2 (MBO Cony)
TEP 4: CHAIN OF CUSTODY - I	INITIATED BY COLLECTO	OR AND COMPLETE	ED BY TEST FACILIT	Υ	
certify that the specimen given to mollected, labeled, sealed and released					TTLE(S) RELEASED TO:
	ŕ				
	Signature of Collecto	or		AM	
(PRINT) Collector's Na	ame (First, MI, Last)	// Date (Mo/Day/Yr	Time of Collection	PM Name	of Delivery Service
EP 5: COMPLETED BY DONO		Julo (mo/Juj/ 11	,	Trains	5. 20.110. y Co.1100
ny presence; and that the informati ,	ion provided on this form an	nd on the label affixed	to each specimen bott	le is correct.	
Signature o			, ,	ame (First, MI, Last)	Date (Mo/Day/Yr)
aytime Phone No. ()		Evening Phone No	D. <u>(</u>	Date	of Birth/ (Mo/Day/Yr)
		te for the enecimen	identified by this for	m, he/she may contact you	to ask about prescriptions a
ver-the-counter medications yell IECESSARY. If you choose to	ou may have taken. Then make a list, do so either	refore, you may war r on a separate pied	ce of paper or on th	nose medications for your o ne back of your copy (Copy	wn records. THIS LIST IS NO 5). – DO NOT PROVIDE TH
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	SPECIMEN ID NO.	00000	ЮŢ		
STEP 1: COMPLETED BY COLLECT		RESENTATIVE		ACCESSION NO.	
A. Employer Name, Address, I.D. No.			B. MRO Name, Add	dress, Phone No. and Fax No.	
C. Donor SSN or Employee I.D. No D. Specify Testing Authority: HHS E. Reason for Test: Pre-employment Drug Tests to be Performed: G. Collection Site Address:	S NRC Specify Random Reasonable S	DOT Agency:	FMCSA FAA Post Accident Retr COC Only Ot	her (specify)	(specify)
				Collector Phone No	
				Collector Fax No	
STEP 2: COMPLETED BY COLLECT					
Temperature between 90° and 100° F?	Yes No, Enter Remark	Collection:	Split Single	None Provided, Enter Remark	Observed, Enter Remark
STEP 3: Collector affixes bottle sea					n Copy 2 (MRO Copy)
certify that the specimen given to me by collected, labeled, sealed and released to t	y the donor identified in the cei	rtification section on	Copy 2 of this form v	vas SPECIMEN BOTT	LE(S) RELEASED TO:
X	Signature of Collector			AM	
				РМ	
(PRINT) Collector's Name (TEP 5: COMPLETED BY DONOR	First, MI, Last)	Date (Mo/Day/Yr)	Time of Collection	Name of I	Delivery Service
Signature of Do Daytime Phone No. () After the Medical Review Officer re	Ev	•	,	Date of	//
over-the-counter medications you on NECESSARY. If you choose to ma INFORMATION ON THE BACK OF STEP 6: COMPLETED BY MEDICAL	may have taken. Therefore lke a list, do so either on a F ANY OTHER COPY OF	e, you may want a separate piece THE FORM. TAI	to make a list of th of paper or on the KE COPY 5 WITH	ose medications for your owr e back of your copy (Copy 5)	n records. THIS LIST IS NO
In accordance with applicable Federal I		is:			
DILUTE					
☐ REFUSAL TO TEST because – ch ☐ ADULTERATED (adultera ☐ SUBSTITUTED ☐ OTHER:	` '				ANCELLED
REMARKS:					
X					
Signature of Medical I			-HINT) MEDICAL REVIEW C	Officer's Name (First, MI, Last)	Date (Mo/Day/Yr)
In accordance with applicable Federal I	•	, ,	,	TEST C	ANCELLED
FAILED TO RECONFIRM for:					
REMARKS:					
Signature of Medical I	Baylow Officer		DDINT\ Madical Daview C	Officer's Name (First ML Last)	Date (Mo/Day/Vr)

\bigcirc	Paper CCF: Back of Copy 1-4 Electronic CCF: Separate Page	\circ		
\bigcirc	Public Burden Statement:	0		
\bigcirc	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	\bigcirc		
\bigcirc	collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57B, Rockville, Maryland, 20852.			
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SPECIMEN ID NO. 000001

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRI		ACCESSION NO.
A. Employer Name, Address, I.D. No.	B. MHO Name, Addres	ss, Phone No. and Fax No.
C. Donor SSN or Employee I.D. No		
D. Specify Testing Authority: HHS NRC Specify	DOT Agency: FMCSA FAA	☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
E. Reason for Test: Pre-employment Random Reasonable St	uspicion/Cause	to Duty Follow-up Other (specify)
EDrug Tests to be Performed: THC, COC, PCP, OPI, AMP Co. Collection Site Address:	☐ THC & COC Only ☐ Other	(specify)
a. Concention one Address.	Col	lector Phone No
	Cal	lector Fax No.
TEP 2: COMPLETED BY COLLECTOR (make remarks when a		
emperature between 90° and 100° F? Yes No, Enter Remark	Collection: Split Single	None Provided, Enter Remark Observed, Enter Remar
REMARKS		. ,
TEP 3: Collector affixes bottle seal(s) to bottle(s). Collector of TEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AN	lates seal(s). Donor initials seal(s). Do	onor completes STEP 5 on Copy 2 (MRO Copy)
certify that the specimen given to me by the donor identified in the cert	ification section on Copy 2 of this form was	SPECIMEN BOTTLE(S) RELEASED TO:
ollected, labeled, sealed and released to the Delivery Service noted in acco	ordance with applicable Federal requirements.	
(
Signature of Collector	AM	
(PRINT) Collector's Name (First, MI, Last)	/	Name of Delivery Service
TEP 5: COMPLETED BY DONOR	,	
Signature of Donor	(PRINT) Donor's Name (
Daytime Phone No. () Eve	ening Phone No()	Date of Birth/ / (Mo/Day/Yr)
After the Medical Review Officer receives the test results for to over-the-counter medications you may have taken. Therefore, NECESSARY. If you choose to make a list, do so either on a NFORMATION ON THE BACK OF ANY OTHER COPY OF	you may want to make a list of those separate piece of paper or on the b	ne/she may contact you to ask about prescriptions are medications for your own records. THIS LIST IS NC ack of your copy (Copy 5). – DO NOT PROVIDE THI
TEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMA		
n accordance with applicable Federal requirements, my verification is	S:	
NEGATIVE POSITIVE for:		
☐ DILUTE ☐ REFUSAL TO TEST because – check reason(s) below:		☐ TEST CANCELLED
ADULTERATED (adulterant/reason):		
SUBSTITUTED		
OTHER:		
REMARKS:		
Signature of Medical Review Officer	(PRINT) Medical Review Office	er's Name (First, MI, Last)
TEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT n accordance with applicable Federal requirements, my verification for	SPECIMEN	Er 3 Manie (Frist, Wi, Last)
RECONFIRMED for:	, , , , ,	TEST CANCELLED
FAILED TO RECONFIRM for:		
_		
REMARKS:		
Signature of Medical Review Officer	(PRINT) Medical Review Office	er's Name (First, MI, Last)
- 3	(,	

	Paper CCF: Back of Copy 5	C
	Electronic CCF: Separate Page Instructions for Completing the Federal Drug Testing Custody and Control Form for Urine Specimen Collection	
\cup	When making entries on a paper CCF, use black or blue ink pen and press firmly	
\bigcirc	Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory are on the top of the Federal CCF and the Specimen I.D. number on the top of the Federal CCF matches the Specimen I.D. number on the labels/seals.	C
\bigcirc	 STEP 1: Collector ensures that the required information is in STEP 1. Collector enters a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee I.D. number. 	C
\bigcirc	 Collector gives collection container to Donor and instructs Donor to provide a specimen. Collector notes any unusual behavior or appearance of Donor in the remarks line in STEP 2. If the Donor's conduct at any time during the collection process clearly indicates an attempt to tamper with the specimen, Collector notes the conduct in the remarks line in STEP 2 and takes action as required. 	C
	STEP 2:	
	 Collector checks specimen temperature within 4 minutes after receiving the specimen from Donor, and marks the appropriate temperature box in STEP 2. If temperature is outside the acceptable range, Collector enters a remark in STEP 2 and takes action as required. 	
	 Collector inspects the specimen and notes any unusual findings in the remarks line in STEP 2 and takes action as required. Any specimen with unusual physical characteristics (e.g. unusual color, presence of foreign objects or material, unusual odor) cannot be sent to an IITF and must be sent to an HHS-certified laboratory for testing as required 	
	 Collector determines the volume of specimen in the collection container. If the volume is acceptable, Collector proceeds with the collection. If the volume is less than required by the federal agency, Collector takes action as required, and enters remarks in STEP 2. If no specimen is collected by the end of the collection process, Collector checks the <i>None Provided</i> box, enters a remark in STEP 2, 	
	discards Copy 1 and distributes remaining copies as required.	C
\bigcirc	 Collector checks the Split or Single specimen collection box. If the collection is observed, Collector checks the Observed box and enters a remark in STEP 2. 	C
	• Donor watches Collector pour the specimen from the collection container into the specimen bottle(s), place the cap(s) on the specimen	
	 bottle(s), and affix the label(s)/seal(s) on the specimen bottle(s). Collector dates the specimen bottle label(s)/seal(s) after placement on the specimen bottle(s). 	
	 Donor initials the specimen bottle label(s)/seal(s) after placement on the specimen bottle(s). 	
	 Collector instructs the Donor to read and complete the certification statement in STEP 5 on Copy 2 (signature, printed name, date, phone numbers, and date of birth). If Donor refuses to sign the certification statement, Collector enters a remark in STEP 2 on Copy 1. 	
\bigcirc	STEP 4:	\subset
	 Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service) and places the sealed specimen bottle(s) in a leak-proof plastic bag. 	
	 Paper CCF: Collector places Copy 1 in the leak-proof plastic bag. Electronic CCF: Collector places printed copy of Copy 1 in the leak-proof plastic bag and/or places package label (with Specimen I.D., test facility name and contact information, and collection site name and contact information) on the outside of the bag. 	
	 Collector seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required. 	С
	Privacy Act Statement: (For Federal Employees Only)	
\bigcirc	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.	
\bigcirc	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	C
\bigcirc	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.	C
\bigcirc	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	C
	number or other identifier will be assigned, as required, to process the specimen.	
	Public Burden Statement Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information	
\bigcirc	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	C
	reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57B, Rockville, Maryland, 20852.	