

D 2586158

245 Pall Mall St., London, ON N6A 1P4

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.

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

ABC Trucking
123 Plains St.
Grande Prairie, AB T8W 0A4
DEB-Bob Health 866-123-4567

Dr. Trevor Gilmore
C.M.R.O.
D-122 Commerce Park Dr.
Barrie ON L4N 8W8
P-866-481-0361 F-905-828-9999

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

S4578632003492 ON 0L

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:

WeCollect

Collector Contact Info: Phone

8663332244

Collector Contact Info: Fax

7602349922

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:

57020

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

SAMMY TESTOR

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

Time of Collection

03:15

☐ AM ☒ PM

Date (Mo./Day/Yr.)

02/23/2022

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

Name of Delivery Service Transferring Specimen to Lab

☐ Dynacare

☒ Purolator

☐ Other

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

gsingh148@gmail.com

Email address

Daytime Phone No.

594322211

Evening Phone No. ()

Date of Birth

02/23/2022

Date (Mo./Day/Yr.)

12/12/1985

(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:

REGULAR DOT COLLECTION

X

Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.

ABC Trucking
123 Plains St.
Grande Prairie, AB T8N 9A4
DER-Bob Health 866-123-4567

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

Dr. Trevor Gillmore
CMRO
D-122 Commerce Park Dr.
Berrie, ON L4N 8W8
P-905-481-0361 F-705-995-8288

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

DD 4369299734821 ON OL

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: We collect
989 Holly St.
Grande Prairie, AB T83 103

Collector
Contact
Info: Phone

8663334422

Collector
Contact
Info: Fax

7802349922

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: Observed, 2 of 2, 1st TOR D2586157 Observed by Sam Smith 57020 ID 67892

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 Smith
Signature of Collector

Time of
Collection

11:40

☒ AM
☐ PM

Date
(Mo./Day/Yr.)

03/15/2022

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

Name of Delivery Service Transferring Specimen to Lab

☐ Dynacare

☐ Purolator

☐ Other _____

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 tyrone dingwal
Signature of Donor

TYRONE DINGWAL

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

03/15/2022

Date (Mo/Day/Yr)

tdingwal789@hotmail.com

Email address

Daytime Phone No. 416 221-0324

Evening Phone No. ()

Date of Birth

11/6/1979

(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: _____

OBSERVED DOT COLLECTION

X _____
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo/Day/Yr)

D 2586160

245 Pall Mall St., London, ON N6A 1P4

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.

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

ABC Trucking
123 Plains St.
Grande Prairie, AB T8N 0A4
DEF - Bob Health 866-123-4567

Dr. Trevor Guilmore
CMPO
D-122 Commerce Park Dr.
Berrie, ON L4N 8W8
P. 905-481-0361 F. 705-999-8228

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

K73200099231 ON AL

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: We Collect

Collector
Contact
Info: Phone

8663334422

Collector
Contact
Info: Fax

7802349922

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: Donor refused to initial vials & sign step 5 57020

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]
Signature of Collector

Time of
Collection

01:42

☐ AM
☐ PM

Date
(Mo./Day/Yr.)

04/18/2022

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

Name of Delivery Service Transferring Specimen to Lab

☒ Dynacare

☐ Purolator

☐ Other _____

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

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]
Signature of Donor

RONALD KEREWACK

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

04/18/2022

Date (Mo/Day/Yr)

Email address

rkereuack321@gmail.com

Daytime Phone No. 75431-2322

Evening Phone No. ()

Date of Birth

06/17/1980

(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]
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: _____

REFUSAL TO INITIAL AND SIGN DOT COLLECTION

X [Signature]
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo/Day/Yr)

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.

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

ABC Trucking
123 Plains St.
Grande Prairie, AB T8W 8A4
DER- Bob Health 866-123-4567

Dr. Trevor Guilmore
CMRB
D-122 Commerce Park Dr.
Berrie, ON L4N 8W8
p-905-481-0361 f-705-999-8288

C. Donor SSN or 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:

We Collect

Collector
Contact
Info: Phone

8663334422

Collector
Contact
Info: Fax

7802349922

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: TOR - 1 of 2, see 2nd Observed collection D2586156 57020

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

Time of
Collection

11:25

☐ AM
☐ PM

Date

(Mo./Day/Yr.)

03/15/2022

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

Name of Delivery Service Transferring Specimen to Lab

☐ Dynacare

☐ Purolator

☐ Other _____

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

TYRONE DINGWAL

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

03/15/2022

Date (Mo/Day/Yr)

Email address

Daytime Phone No.

416 221-0324

Evening Phone No. ()

Date of Birth

11/6/1979

(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: _____

TEMPERATURE OUT OF RANGE DOT COLLECTION

X

Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo/Day/Yr)

D 2586173

245 Pall Mall St., London, ON N6A 1P4

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.

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

ABC Trucking
123 Plains St.
Grande Prairie, AB T8W 0B4
DEK - Bob Health 866-123-4567

Dr. Trevor Gilmore
CMRO
D-122 Commerce Park Dr.
Burnie, ON L4N 8W8
p. 866-324-7093 f. 705-999-8228

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

M274932006924 ON 04

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:

Wecollect
989 Holly St.
Grande Prairie, AB T8S 1B3

Collector
Contact
Info: Phone

8663334422

Collector
Contact
Info: Fax

7802349922

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: Shy bladder start 12:00 ends 3pm. See Shy Bladder log 57020

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

Time of
Collection

12:40

☐ AM
☒ PM

Date

07/21/2022

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

Name of Delivery Service Transferring Specimen to Lab

☐ Dynacare

☒ Purolator

☐ Other

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
Zmalinwa@gmail.com
Email address

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

07/21/22
Date (Mo/Day/Yr)

Daytime Phone No. 75 331-2244

Evening Phone No. ()

5/17/1990
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)

SHY BLADDER