Dynacare

D 2586158

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	Dr. Trevor Gilmore
	CMRO DID
Grande Prairie, NO 1840	D-122 Commerce Perk N.
DER-Bob Health 866-123-4567	BOTTIE ON LYN8W8
	P.866281-0361 F-965-828-7777
C. Donor SSN or Employee I.D., or CDL State and No.	16329934914 ON 1014
D. Specify Testing Authority: HHS NRC Specify DOT Agency:	☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
E. Reason for Test: Pre-employment Random Reasonable Suspicion/Cau	
F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP THE G. Collection Site Address: Collector	IC & COC Only Other (specify)
989 Holly St. Contact Info: Phone	3332244 Contact 7602349924
Grande Prairie AB T85 173	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	
ORAL FLUID: Split Type: Serial Concurrent Subdivided Each Dev	rice 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). Done STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED	워크림 경영
I certify that the specimen given to me by the donor identified in the certification section on Co	
accordance with applicable federal requirements. Time of	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO
Signature of Collector Collection	PM Name of Benvery Service transferring Speciment to East
Date (Mo./Day/Yr.)	232
STEP 5: COMPLETED BY DONOR	
I certify that I provided my specimen to the collector; that I have not adulterated it in a	ny manner; each specimen bottle/tube used was sealed with a tamper-evident sea
in my plesence; and that the information provided on this form and on the label affixed	
	2JIT SINGH 02, 23, 20,
9519h 148 Email address Donor Daytime Phone No. 59 432221	(PRINT) Donor's Name (First, MI, Last) Evening Phone No. () Date of Birth Date (Mo/Day/Yr) (Mo/Day/Yr)
After the Medical Review Officer receives the test results for the specimen idea over-the-counter medications you may have taken. Therefore, you may want to NECESSARY. If you choose to make a list, do so either on a separate piece of INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE	make a list of those medications for your own records. THIS LIST IS NOT paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN	URINE ORAL FLUID
In accordance with applicable federal requirements, my verification is:	
NEGATIVE POSITIVE for:	
REFUSAL TO TEST because – check reason(s) below:	TEST CANCELLED
ADULTERATED (adulterant/reason):	
SUBSTITUTED	
OTHER:	
REMARKS:	
v.	
^	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 specime	
RECONFIRMED for:	TEST CANCELLED
FAILED TO RECONFIRM for:	
REMARKS:	
REGULAR DO	T COLLECTION
Y	

Signature of Medical Review Officer

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

Date (Mo/Day/Yr)

Dynacare

D 2586156

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTAT	IVE SPECIMEN ID NO. ACCESSION NO.
A. Employer Name, Address, I.D. No.	B. MRO Name, Address, Phone No. and Fax No.
ABC Trucking	Dr. Trevor Gillmore
123 Plains St. 10 - MI	CMRO DILA
Exercise, AS TON 949	D-122 Commande this w
DER-Bob Health 866-123-4567	D-905-481-0361 f-705-999-8288
N. A. A.	2/
C. Donor SSN or Employee I.D., or CDL State and No.	369747977978411979194
D. Specify Testing Authority: HHS NRC Specify DOT Ag	
 E. Reason for Test: □ Pre-employment □ Random □ Reasonable Suspic F. Drug Tests to be Performed: □ THC, COC, PCP, OPI, AMP 	ion/Cause Post Accident Return to Duty Follow-up Other (specify)
G. Collection Site Address: We Collect Contact	42334477Z Collector 780034997ZZ
Exercle fruirie AB T83 103 Info: Phone Lot	Other
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriat	
COLLECTION: Split Single None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature	
	ach Device Within Expiration Date?
REMARKS: Observed 2 05 2 1st TOR	D2586157 Observed by San Smith 57020 189
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s)	
STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMP	
	on on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO
X Time of Collection	AM Name of Delivery Service Transferring Specimen to Lab
Signature of Collector Date	□ Dynacare □ Purolator
(PRINT) Collector's Name (First, MI, Last)	0ther
STEP 5: COMPLETED BY DONOR	
	d it in any manner; each specimen bottle/tube used was sealed with a tamper-evident se
in my presence; and that the information provided on this form and on the labe	
Signature of Donor	YRONE DINGWAL 03 15 7207 (PRINT) Donor's Name (First, MI, Last) Date (Mo/Day/Yr)
tdinghal 789 enot mail compaytime Phone No. 416 221	-0324 Evening Phone No. () Date of Birth 11 /6 197
over-the-counter medications you may have taken. Therefore, you may	nen identified by this form, he/she may contact you to ask about prescriptions and want to make a list of those medications for your own records. THIS LIST IS NOT piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS M. TAKE COPY 5 WITH YOU.
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPEC	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):	TEST CANCELLED
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 SPECIM In accordance with applicable federal requirements, my verification for the split s	
RECONFIRMED for:	TEST CANCELLED
☐ FAILED TO RECONFIRM for:	
REMARKS:	
OBSERVE	D DOT COLLECTION
X	
Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/Day/Yr)

Dynacare®

D 2586160

245 Pail Mail St., London, ON N6A 1P4	
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE	B. MRO Name, Address, Phone No. and Fax No.
A. Employer Name, Address, I.D. No.	Dr. Trevor Eilmore
PBC Trucking	
123 PIGUIS D' 10 TOW OAY	1-122 Commerce Perk, Mr.
Grande Prairie, AB	PRICE ON LYN 8W8
DER-Bob Health 866-123-4567	D.905-481-0361 f-705-999-8228
C. Donor SSN or Employee I.D., or CDL State and No.	DODO99231 ON 04
D. Specify Testing Authority: HHS NRC Specify DOT Agence	cy:
	Cause Post Accident Return to Duty Follow-up Other (specify)
	☐THC & COC Only ☐ Other (specify)
G. Collection Site Address: We Collect Contact Contact	12234477 Collector 1862349922
Grade Prairie AB T83 103	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 bet	tween 90° and 100° F? Yes \(\subseteq No, Enter Remark \) \(\subseteq Observed, Enter Remark \)
	Device Within Expiration Date?
REMARKS: DONOC fotused to initial y	10/5 & 500 SPOS 57020
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). I	
STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLET	TED BY TEST FACILITY
I certify that the specimen given to me by the donor identified in the certification section of accordance with applicable federal requirements.	n Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in
X Time of	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab
Signature of Collector Collection	Dynacare Purolator
(PRINT) Collector's Name (First, MI, Last) Date (Mo./Day/Yr.)	-1182927 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 at	ffixed to each specimen bottle/tube is correct.
X	NALD KEREWARK 04,18,2000
Kerewick321 Comment Phone No. 25431-2	(PRINT) Donor's Name (First, MI, Last) Sevening Phone No. () Date of Birth
over-the-counter medications you may have taken. Therefore, you may war	(Mo/Day/Yr) identified by this form, he/she may contact you to ask about prescriptions and int to make a list of those medications for your own records. THIS LIST IS NOT be of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS TAKE COPY 5 WITH YOU.
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIM	EN 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	하는 사람들은 사람들이 나는 사람들이 가장 하는 사람들이 없었다고 가지 않다.
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 specific and specific accordance with applicable federal requirements.	cimen (if tested) is:
RECONFIRMED for:	TEST CANCELLED
FAILED TO RECONFIRM for:	
REMARKS:	
REFUSAL TO INITIAL	AND SIGN DOT COLLECTION
Y The state of the	

Date (Mo/Day/Yr)

Dynacare

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

D 2586157

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	Dr. Trevor Galmore
173 Plains St. 10	CMRB DILLA
Cocande Prairie, ALP8W DAY	D-12Z commerce its commerce
	Barrie, ON LYN 8NB
DER- Bdo Health 866-123-4567	p-905-481-0361 +-705-999-8280
C. Donor SSN or Employee I.D., or CDL State and No.	9799734871 ON D4
D. Specify Testing Authority: HHS NRC Specify DOT Agency:	□ FMCSA □ FAA □ FRA □ FTA □ PHMSA □ USCG
E. Reason for Test: Pre-employment Random Reasonable Suspicion/Cau	use Post Accident Return to Duty Follow-up Other (specify)
	HC & COC Only Other (specify)
G. Collection Site Address: We Collect Contact Info: Phone 86	3334422 Collector Contact 7802349922
Grade Prairie AB T83 103	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	en 90º and 100º F? Yes No, Enter Remark Observed, Enter Remark
ORAL FLUID: Split Type: Serial Concurrent Subdivided Each De	vice Within Expiration Date?
REMARKS: TOR - 10f 2 sec 2nd Obser	ved collection 02586156 57020
STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Don	0. 0.00
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 C accordance with applicable federal requirements.	
Y Mul Political Time of 1 1	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO Name of Delivery Service Transferring Specimen to Lab
Signature of Collection Collection	□ Dynacare □ Purolator
(PRINT) Collector's Name (First, MI, Last) Date (Mo./Day/Yr.)	1 5 2 0 2 2 Dother
STEP 5: COMPLETED BY DONOR	
I certify that I provided my specimen to the collector; that I have not adulterated it in a	any manner: each specimen hottle/tube used was sealed with a tamper-evident sea
in my presence; and that the information provided on this form and on the label affixed	
x luce	LONE DINGWAL 03,15,200
Signature of Donor	(PRINT) Donor's Name (First MI Last)
+dthgwal789ehotmil. (Baytime Phone No. 416 221-032	Evening Phone No. () Date of Birth / 6 / 17+
After the Medical Review Officer receives the test results for the specimen ide over-the-counter medications you may have taken. Therefore, you may want to	
NECESSARY. If you choose to make a list, do so either on a separate piece of INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAK	
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN	
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) Date (Mo/Day/Yr)
STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN In accordance with applicable federal requirements, my verification for the split specim	en (if tested) is:
RECONFIRMED for:	TEST CANCELLED
FAILED TO RECONFIRM for:	
REMARKS:	
	PANCE DOT COLLECTION
TEWPERATURE OUT OF	RANGE DOT COLLECTION
X	

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

Date (Mo/Day/Yr)

Signature of Medical Review Officer



D 2586173

245 Pall Mall St., London, ON N6A 1P4	P.FOOOTIA
STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTAT	
A. Employer Name, Address, I.D. No.	B. MRO Name, Address, Phone No. and Fax No.
4RC Incharg	Dr. Trevor Gulmore
123 PROBLEMB TSW 084	D-122 COMMErce PCILD.
NEW-BOD FLOGIEL SUG-123-45	67 D866-324-7093 F-705-999-822
DEST-000 LIGHTIN SEC IT - 12	0.866-791-4013 4-403-101-022
C. Donor SSN or Employee I.D., or CDL State and No.	ency: PFMCSA FAA FRA FTA PHMSA USCG
D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Ag E. Reason for Test: ☐ Pre-employment ☐ Reasonable Suspic	
F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP	THC & COC Only Other (specify)
G. Collection Site Address: We Collect Contact Info: Phone	6 4 3 3 3 4 4 Z Z Collector Contact Info: Fax
Corrado Pravirio AB T83 (03	Other
STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate	e). [JURINE []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 Ea	ach Device Within Expiration Date?
REMARKS: Sy bladder Stert 12:00 e	nds 3 pm. See Shy bladder 10,57020
STEP 3: Collector affixes seal(s) to bottle(s)/fube(s). Collector dates seal(s) STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMP	
I certify that the specimen given to me by the donor identified in the certification section	on on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in
accordance with applicable tederal requirements.	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab
Signature of Collector Collection	1290 Lawren
Date (Mo./Day/Yr.)	Dynacare Purolator Other
STEP 5: COMPLETED BY DONOR	
in my presence; and that the information provided on this form and on the labe	ZAHARA MALIWA 07,21,22
Email address Daytime Phone No. 75, 331	2244 (PRINT) Donor's Name (First, MI, Last) Date of Birth Date (Mo/Day/Yr)
over-the-counter medications you may have taken. Therefore, you may	nen identified by this form, he/she may contact you to ask about prescriptions and want to make a list of those medications for your own records. THIS LIST IS NOT piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS INTEREST. IN TAKE COPY 5 WITH YOU.
STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPEC	OMEN URINE ORAL FLUID
In accordance with applicable federal requirements, my verification is: NEGATIVE POSITIVE for:	
☐ DILUTE ☐ REFUSALTO 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 SPECIMI In accordance with applicable federal requirements, my verification for the split s	
RECONFIRMED for:	TEST CANCELLED
FAILED TO RECONFIRM for:	
REMARKS:	
CHV F	BLADDER
X	
Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo/Day/Yr)