

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



D2440947

LAB USE ONLY

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.

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:

Collector Contact Info: Phone

Collector Contact Info: 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:

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

AM PM

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

Name of Delivery Service Transferring Specimen to Lab

Dynacare

Purolator

Other

Date

(Mo./Day/Yr)

RECEIVED AT LAB OR IITF:

X

Signature of Accessioner

Primary Specimen Seal Intact

YES NO

If NO, Enter remark in Step 5A.

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

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

Date (Mo/Day/Yr)

Primary/Single Specimen Device Expiration Date: / /

(Mo/Day/Yr)

Split Specimen Device Expiration Date: / /

(Mo/Day/Yr)

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

NEGATIVE REJECTED FOR TESTING ADULTERATED SUBSTITUTED INVALID RESULT

DILUTE

POSITIVE for:

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 procedures, analyzed, and reported in accordance with applicable federal requirements.

X

Signature of Certifying Technician / Scientist

(PRINT) Certifying Technician / Scientist's Name (First, MI, Last)

Date (Mo/Day/Yr)

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

RECONFIRMED FAILED TO RECONFIRM - REASON

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.

Laboratory Name

Laboratory Address

X

Signature of Certifying Scientist

(PRINT) Certifying Scientist's Name (First, MI, Last)

Date (Mo/Day/Yr)



D2440947



A

Date (Mo Day Yr)

Donor's Initials



D2440947



B SPLIT

Date (Mo Day Yr)

Donor's Initials

D 2440947

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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.

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 USCGE. 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

Collector Contact Info: Fax

Other

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

Signature of Collector

Time of Collection

 AM PM**SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:**

Name of Delivery Service Transferring Specimen to:

 Dynacare Purolator Other

Date (Mo./Day/Yr.)

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.

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:

 ADULTERATED (adulterant/reason): _____ SUBSTITUTED OTHER: _____ TEST CANCELLED

REMARKS:

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:

Signature of Medical Review Officer

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

Date (Mo/Day/Yr)

FORM -COC-DOTE (08/02)

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