

- 69 First Ave., Raritan, NJ 08869
- 1904 T.W. Alexander Dr., Research Triangle Park, NC 27709
- 1120 Main Street, Southaven, MS 38671
- 7207 North Gessner, Houston, TX 77040

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 1234567890

ACCESSION NO. 1234567890

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. <b>FIRSTSOURCE SOLUTIONS FIRSTSOURCE SOLUTIONS(DOT) 100 HIGHPOINT DR. STE 102 CHALFONT, PA 18914 Phone: (215)396-5500 Fax: (215)396-5528</b>		B. MRO Name, Address, Phone No. and Fax No. <b>DR. RANDY BARNETT D.O. FSSOLUTIONS 100 HIGHPOINT DR.,STE.102 CHALFONT, PA 18914 Phone: (215)396-5500 Fax: (215)396-5610</b>		
C. Donor SSN or Employee I.D. No. <b>D O N O R I D</b>				
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG				
E. Reason for Test: <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify)				
F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input checked="" type="checkbox"/> Other (specify) <b>708392</b>				
G. Collection Site Address: <b>- DFLTSITE 1515 Main St MYSORE, TX 12345</b>				
			Collector Phone No. <b>(123)555-9999</b>	
			Collector Fax No. <b>(123)555-9999</b>	

OMB No. 0930-0158

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F?  Yes  No, Enter Remark Collection:  Split  Single  None Provided, Enter Remark  Observed, Enter Remark

REMARKS **EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT! EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT!**

STEP 3: Collector affixes bottle seal(s) to bottle(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.

<b>X</b>	Signature of Collector	AM	SPECIMEN BOTTLE(S) RELEASED TO:	
<b>Joe Collector</b>	<b>01/ 13 /21</b>	<b>08:53 AM EST</b>	<b>LabCorp Courier</b>	
(PRINT) Collector's Name (First, MI, Last)	Date (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:
<b>X</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature of Accessioner	If NO, Enter remark in Step 5A.	
(PRINT) Accessioner's Name (First, MI, Last)	Date (Mo/Day/Yr)	

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

**NEGATIVE**  **POSITIVE** for:  Marijuana Metabolite (Δ9-THCA)  Methamphetamine  MDMA  6-Acetylmorphine  OXYC  HYC  
 DILUTE  Cocaine Metabolite (BZE)  Amphetamine  MDA  Morphine  OXYM  HYM  
 PCP  Codeine

**REJECTED FOR TESTING**  **ADULTERATED**  **SUBSTITUTED**  **INVALID RESULT**

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** \_\_\_\_\_ (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr)

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

Laboratory Name	<input type="checkbox"/> <b>RECONFIRMED</b> <input type="checkbox"/> <b>FAILED TO RECONFIRM - REASON</b> _____
Laboratory Address	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.
Signature of Certifying Scientist	<b>X</b> _____ (PRINT) Certifying Scientist's Name (First, MI, Last) _____ Date (Mo/Day/Yr)

COPY 1 - TEST FACILITY COPY

CONTAINER SEAL  
**WEB-FED**  
1100 URINE

1234567890

1234567890

1234567890

1234567890

1234567890

FED + A

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

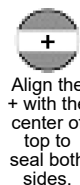
\_\_\_\_\_  
Donor's Initials

FED + B

SPLIT

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Donor's Initials



- 69 First Ave., Raritan, NJ 08869
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- 7207 North Gessner, Houston, TX 77040

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



1234567890

SPECIMEN ID NO. 1234567890

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

<p>A. Employer Name, Address, I.D. No.  <b>FIRSTSOURCE SOLUTIONS</b>  <b>FIRSTSOURCE SOLUTIONS(DOT)</b>  <b>100 HIGHPOINT DR. STE 102</b>  <b>CHALFONT, PA 18914</b>          Phone: (215)396-5500 Fax: (215)396-5528</p>	<p>B. MRO Name, Address, Phone No. and Fax No.  <b>DR. RANDY BARNETT D.O.</b>  <b>FSSOLUTIONS</b>  <b>100 HIGHPOINT DR.,STE.102</b>  <b>CHALFONT, PA 18914</b>          Phone: (215)396-5500 Fax: (215)396-5610</p>
<p>37146290</p>	
<p>C. Donor SSN or Employee I.D. No. <b>D O N O R I D</b></p>	
<p>D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG</p>	
<p>E. Reason for Test: <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify)</p>	
<p>F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC &amp; COC Only <input checked="" type="checkbox"/> Other (specify) <b>708392</b></p>	
<p>G. Collection Site Address:  <b>- DFLTSITE</b>  <b>1515 Main St</b>  <b>MYSORE, TX 12345</b></p>	
<p>Collector Phone No. (123)555-9999</p> <p>Collector Fax No. (123)555-9999</p>	

**STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.**

Temperature between 90° and 100° F?  Yes  No, Enter Remark      Collection:  Split  Single  None Provided, Enter Remark       Observed, Enter Remark

REMARKS **EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT! EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT!**

**STEP 3: Collector affixes bottle seal(s) to bottle(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**

<p><i>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.</i></p> <p><b>X</b> _____          Signature of Collector <span style="float: right;">AM</span></p> <p style="text-align: center;"><b>Joe Collector</b>      <b>01/ 13 /21</b>      <b>08:53 AM EST</b> PM  <small>(PRINT) Collector's Name (First, MI, Last)      Date (Mo/Day/Yr)      Time of Collection</small></p>	<p style="text-align: center;"><b>SPECIMEN BOTTLE(S) RELEASED TO:</b></p> <p style="text-align: center;"><b>LabCorp Courier</b>  <small>Name of Delivery Service</small></p>
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**STEP 5: COMPLETED BY DONOR**

*I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.*

**X** \_\_\_\_\_  
 Signature of Donor **Joe Donor**

(PRINT) Donor's Name (First, MI, Last)      Date (Mo/Day/Yr)

Daytime Phone No. ( **919** ) **123-4567**      Evening Phone No. ( **919** ) **123-4567**      Date of Birth **11 / 01 / 68**  
(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**

*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)

- 69 First Ave., Raritan, NJ 08869
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- 7207 North Gessner, Houston, TX 77040

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



1234567890

SPECIMEN ID NO. 1234567890

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.  
**FIRSTSOURCE SOLUTIONS**  
**FIRSTSOURCE SOLUTIONS(DOT)**  
**100 HIGHPOINT DR. STE 102**  
**CHALFONT, PA 18914**  
 Phone: (215)396-5500 Fax: (215)396-5528

B. MRO Name, Address, Phone No. and Fax No.  
**DR. RANDY BARNETT D.O.**  
**FSSOLUTIONS**  
**100 HIGHPOINT DR.,STE.102**  
**CHALFONT, PA 18914**  
 Phone: (215)396-5500 Fax: (215)396-5610

C. Donor SSN or Employee I.D. No. **D O N O R I D**

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) **708392**

G. Collection Site Address:  
**- DFLTSITE**  
**1515 Main St**  
**MYSORE, TX 12345**

Collector Phone No. **(123)555-9999**  
 Collector Fax No. **(123)555-9999**



37146290

OMB No. 0930-0158

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F?  Yes  No, Enter Remark Collection:  Split  Single  None Provided, Enter Remark  Observed, Enter Remark

REMARKS **EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT! EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT!**

STEP 3: Collector affixes bottle seal(s) to bottle(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 AM

**Joe Collector** **01/ 13 /21** **08:53 AM EST PM**  
 (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection

**LabCorp Courier**  
 Name of Delivery Service

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.

**X** \_\_\_\_\_  
 Signature of Donor

**Joe Donor** **01 / 13 / 21**  
 (PRINT) Donor's Name (First, MI, Last) Date (Mo/Day/Yr)

Daytime Phone No. ( **919** ) **123-4567** Evening Phone No. ( **919** ) **123-4567** Date of Birth **11 / 01 / 68**  
 (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

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)

- 69 First Ave., Raritan, NJ 08869
- 1904 T.W. Alexander Dr., Research Triangle Park, NC 27709
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- 7207 North Gessner, Houston, TX 77040

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



1234567890

SPECIMEN ID NO. 1234567890

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.  
**FIRSTSOURCE SOLUTIONS**  
**FIRSTSOURCE SOLUTIONS(DOT)**  
**100 HIGHPOINT DR. STE 102**  
**CHALFONT, PA 18914**  
 Phone: (215)396-5500 Fax: (215)396-5528

B. MRO Name, Address, Phone No. and Fax No.  
**DR. RANDY BARNETT D.O.**  
**FSSOLUTIONS**  
**100 HIGHPOINT DR.,STE.102**  
**CHALFONT, PA 18914**  
 Phone: (215)396-5500 Fax: (215)396-5610

C. Donor SSN or Employee I.D. No. **D O N O R I D**

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) **708392**

G. Collection Site Address:  
**- DFLTSITE**  
**1515 Main St**  
**MYSORE, TX 12345**

Collector Phone No. **(123)555-9999**  
 Collector Fax No. **(123)555-9999**

OMB No. 0930-0158

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F?  Yes  No, Enter Remark Collection:  Split  Single  None Provided, Enter Remark  Observed, Enter Remark

REMARKS **EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT! EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT!**

STEP 3: Collector affixes bottle seal(s) to bottle(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 **AM**

**Joe Collector** **01/ 13 /21** **08:53 AM EST PM**

(PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection

SPECIMEN BOTTLE(S) RELEASED TO:  
**LabCorp Courier**  
 Name of Delivery Service

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.

**X** Signature of Donor **Joe Donor** **01 / 13 / 21**

(PRINT) Donor's Name (First, MI, Last) Date (Mo/Day/Yr)

Daytime Phone No. ( **919** ) **123-4567** Evening Phone No. ( **919** ) **123-4567** Date of Birth **11 / 01 / 68**

(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

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)

- 69 First Ave., Raritan, NJ 08869
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FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



1234567890

SPECIMEN ID NO. 1234567890

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

<p>A. Employer Name, Address, I.D. No.  <b>FIRSTSOURCE SOLUTIONS</b>  <b>FIRSTSOURCE SOLUTIONS(DOT)</b>  <b>100 HIGHPOINT DR. STE 102</b>  <b>CHALFONT, PA 18914</b>          Phone: (215)396-5500 Fax: (215)396-5528</p>	<p>B. MRO Name, Address, Phone No. and Fax No.  <b>DR. RANDY BARNETT D.O.</b>  <b>FSSOLUTIONS</b>  <b>100 HIGHPOINT DR.,STE.102</b>  <b>CHALFONT, PA 18914</b>          Phone: (215)396-5500 Fax: (215)396-5610</p>
<p>C. Donor SSN or Employee I.D. No. <b>D O N O R I D</b></p>	
<p>D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG</p>	
<p>E. Reason for Test: <input checked="" type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify)</p>	
<p>F. Drug Tests to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC &amp; COC Only <input checked="" type="checkbox"/> Other (specify) <b>708392</b></p>	
<p>G. Collection Site Address:  <b>- DFLTSITE</b>  <b>1515 Main St</b>  <b>MYSORE, TX 12345</b></p>	
<p>Collector Phone No. <b>(123)555-9999</b>          Collector Fax No. <b>(123)555-9999</b></p>	



37146290

OMB No. 0930-0158

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F?  Yes  No, Enter Remark Collection:  Split  Single  None Provided, Enter Remark  Observed, Enter Remark

REMARKS **EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT! EXAMPLE COC FORM - DO NOT USE - DO NOT SUBMIT!**

STEP 3: Collector affixes bottle seal(s) to bottle(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

<p><i>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.</i></p> <p><b>X</b> _____          Signature of Collector AM</p> <p><b>Joe Collector</b> <b>01/ 13 /21</b> <b>08:53 AM EST</b> PM          (PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection</p>	<p>SPECIMEN BOTTLE(S) RELEASED TO:</p> <p><b>LabCorp Courier</b>          Name of Delivery Service</p>
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STEP 5: COMPLETED BY DONOR

*I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.*

**X** \_\_\_\_\_  
 Signature of Donor (PRINT) Donor's Name (First, MI, Last) **Joe Donor** **01 / 13 / 21**  
 Date (Mo/Day/Yr)

Daytime Phone No. ( **919** ) **123-4567** Evening Phone No. ( **919** ) **123-4567** Date of Birth **11 / 01 / 68**  
 (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

*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)