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FAX (509) 922-5281
www.paml.com

PAML PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE 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. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – 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 Phone No. _____

Collector Fax No. _____

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

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

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

__/__/__ Date (Mo/Day/Yr)

AM / PM Time of Collection

SPECIMEN BOTTLE(S) RELEASED TO:

_____ Name of Delivery Service

RECEIVED AT LAB OR IITF:

X _____
Signature of Accessioner

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

__/__/__ Date (Mo/Day/Yr)

Primary Specimen Bottle Seal Intact
☐ YES ☐ NO
If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S) RELEASED TO:

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

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

☐ **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 _____ _____ __/__/__
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

_____ Laboratory Name

_____ Laboratory Address

☐ **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.

X _____ _____ __/__/__
Signature of Certifying Scientist (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo./Day/Yr.)

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

A
SPECIMEN ID NO.

B
SPECIMEN ID NO.

HINGE
PLACE OVER CAP
LATCH
HINGE
PLACE OVER CAP
LATCH

__/__/__ Date (Mo./Day/Yr.)
_____ Donor's Initials
__/__/__ Date (Mo./Day/Yr.)
_____ Donor's Initials

BOX SEAL

COPY 1 - TEST FACILITY COPY

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PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

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

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

OMB No. 0930-0158

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – 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 Phone No. _____

Collector Fax No. _____

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

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.

SPECIMEN BOTTLE(S) RELEASED TO:

X _____
Signature of Collector

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

_____ **Date (Mo/Day/Yr)**

AM / PM _____ **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 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)** **Date (Mo/Day/Yr)**

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

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)**

COPY 2 - MEDICAL REVIEW OFFICER COPY

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PAML PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

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

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

OMB No. 0930-0158

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – 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 Phone No. _____

Collector Fax No. _____

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

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.

SPECIMEN BOTTLE(S) RELEASED TO:

X _____
Signature of Collector

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

__/__/__ **Date (Mo/Day/Yr)**

AM / PM **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 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)** **Date (Mo/Day/Yr)**

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

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)**

COPY 3 - COLLECTOR COPY

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PAML PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

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

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

OMB No. 0930-0158

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – 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 Phone No. _____

Collector Fax No. _____

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

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.

SPECIMEN BOTTLE(S) RELEASED TO:

X _____
Signature of Collector

_____ / / AM 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 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)** **Date (Mo/Day/Yr)**

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

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)**

COPY 4 - EMPLOYER COPY

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PAML PATHOLOGY ASSOCIATES MEDICAL LABORATORIES

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE ACCESSION NO.

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

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

OMB No. 0930-0158

C. Donor SSN or Employee I.D. No. _____

D. Specify Testing Authority: ☐ HHS ☐ NRC ☐ DOT – 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 Phone No. _____

Collector Fax No. _____

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

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.

SPECIMEN BOTTLE(S) RELEASED TO:

X _____
Signature of Collector

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

__/__/__ **Date (Mo/Day/Yr)**

AM / PM **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 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)** **Date (Mo/Day/Yr)**

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

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)**

COPY 5 - DONOR COPY

REORDER #0782 REV. 01/14

Public Burden Statement:

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 collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

8510046703

Instructions for Completing the Federal Drug Testing Custody and Control Form

When making entries use black or blue ink pen and press firmly

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 CCF and that the Specimen I.D. number on the top of the CCF matches the Specimen I.D. number on the labels/seals.

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.
- 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 Donor 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.

B-5A

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 *None Provided* box, enters a remark in STEP 2, discards Copy 1 and distributes remaining copies as required.
- 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.

STEP 3:

- 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 turns to Copy 2 (Medical Review Officer Copy) and instructs Donor to read and complete the certification statement in STEP 5 (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.

STEP 4:

- Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service), places the sealed specimen bottle(s) and Copy 1 of the CCF in a leak-proof plastic bag, seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required.

Privacy Act Statement: (For Federal Employees Only)

Submission of the information on the attached form is voluntary. However, incomplete submission of the information, refusal to provide a urine 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.

The authority for obtaining the urine 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 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.

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 number or other identifier will be assigned, as required, to process the specimen.

Public Burden Statement:

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 collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

8510046703