

West Ouachita Public Transit

Substance Abuse Management Policy

June 20, 2023

West Ouachita Public Transit
Substance Abuse Management Policy
In accordance with USDOT and FTA Regulations

West Ouachita Public Transit is dedicated to providing safe, dependable, and economical transportation service to its patrons. West Ouachita Public Transit employees are a valuable resource and it is our agency's goal to provide a safe, healthy and satisfying working environment, free of the potential dangers posed by a safety-sensitive employee's use of prohibited drugs or misuse of alcohol.

This policy is established to comply with the Federal Transit Administration regulations codified as 49 CFR Part 655, as amended and USDOT regulations codified as 49 CFR Part 40, as amended. ***Policy provisions authorized by West Ouachita Public Transit are italicized and bolded throughout this policy.*** All other policy provisions are implemented under the authority of the United States Department of Transportation (USDOT) and the Federal Transit Administration (FTA).

This policy is approved by: Staci Albritton Mitchell

Title of approving official: Mayor

Signature of approving official: Staci A. Mitchell

Date signed: 6/20/23

Policy effective date: 6/20/23

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1. **Testing Program Background**

The Omnibus Transportation Employee Testing Act of 1991 (OTETA) directed the United States Department of Transportation (USDOT) to promulgate regulations outlining the procedures for transportation workplace drug and alcohol testing. The USDOT regulations titled, "Procedures for Transportation Workplace Drug and Alcohol Testing" are codified as 49 CFR Part 40. The regulations ensure uniform practices for specimen collections, laboratory analysis, medical review, result reporting and the Return-to-Duty process for violating employees. The regulations are applicable to safety-sensitive employees in transportation workplaces throughout the nation (transit, railroad, aviation, commercial drivers, etc.).

The OTETA also directed each transportation administration to craft industry-specific regulations that define which employees are subject to testing, the testing circumstances, policy statement requirements and training requirements, relevant to that industry. West Ouachita Public Transit is required to comply with both the USDOT regulations described above, as well as the Federal Transit Administration regulations "Prevention of Prohibited Drug Use and Alcohol Misuse in Transit Operations" which are codified as 49 CFR Part 655.

2. **Employee Applicability**

This policy and the USDOT/FTA testing program apply to all safety-sensitive West Ouachita Public Transit employees. The policy also applies to volunteers who are required to hold a Commercial Driver's License (CDL) and volunteers that receive remuneration in excess of actual expenses accrued while carrying out assigned duties. Adherence to this policy and the USDOT/FTA testing program is a condition of employment in a safety-sensitive position with West Ouachita Public Transit. All employees of West Ouachita Public Transit who perform, or could be called upon to perform, any of the following duties are defined as safety-sensitive employees:

1. Operate a public transportation vehicle, while in or out of service
2. Operate an ancillary vehicle when the vehicle requires a commercial driver's license
3. Control the movement of a public transportation vehicle
4. Perform maintenance on a vehicle or equipment used in public transportation
5. Carry a firearm as part of transit security detail

The West Ouachita Public Transit positions classified as safety-sensitive include:

- Example job title: Drivers
- Example job title: Dispatchers
- Example job title: Maintenance personnel and Maintenance Supervisor
- Example job title: Managers

3. **USDOT/FTA Prohibited Drug Classes**

Consumption of these drugs is prohibited at all times.

- Amphetamines
- Cocaine
- Marijuana
- Opioids

- CBD products containing THC
- Phencyclidine (PCP)

4. Pre-employment Drug and Alcohol Background Checks

In accordance with 49 CFR Part 40.25, West Ouachita Public Transit must make and document good faith efforts to perform drug and alcohol background checks for all applicants applying for a safety-sensitive position and all current employees applying for transfer into a safety-sensitive position. Testing information will be requested from each of the applicant's previous DOT covered employers during the two years prior to the date of application. West Ouachita Public Transit must obtain the applicant's written consent for the release of their drug and alcohol testing information from their previous DOT covered employers to West Ouachita Public Transit. Applicants refusing to provide written consent are prohibited from performing safety-sensitive functions for West Ouachita Public Transit.

Safety-sensitive applicants who have previously violated the USDOT testing program must provide documentation that they have successfully completed the USDOT's Return-to-Duty process with a DOT-qualified Substance Abuse Professional (SAP). Failure to provide satisfactory documentation will exclude the applicant from being hired or transferred into a safety-sensitive position with West Ouachita Public Transit.

5. Pre-Employment Testing

All applicants for safety-sensitive positions shall undergo a pre-employment urine drug test. West Ouachita Public Transit must receive an MRO-verified negative drug test result prior to the applicant's first performance of any safety sensitive function, including behind-the-wheel training.

If an applicant's pre-employment urine drug test result is verified as positive, the applicant will be excluded from consideration for employment in a safety-sensitive position with West Ouachita Public Transit. The applicant will be provided a list of USDOT-qualified Substance Abuse Professionals.

An employee returning from an extended leave period of 90 consecutive days or more, and whose name was also removed from the random testing pool for 90 days or more, must submit to a pre-employment urine drug test. West Ouachita Public Transit must be in receipt of a negative drug test result prior to the employee resuming any safety-sensitive function.

6. Random Testing

Safety-sensitive employees will be subject to random, unannounced testing. West Ouachita Public Transit will perform random testing in a manner that meets or exceeds the FTA minimum annual testing requirements, as amended. The selection of employees for random testing will be made using a scientifically valid method. All safety-sensitive employees will have an equal chance of being selected each time a random draw is performed. Random alcohol tests will be conducted just before, during or just after the employee's performance of a safety-sensitive

function. Random drug tests may be conducted anytime an employee is on duty, on call for duty or on standby for duty.

Once an employee is notified that they have been selected for a random test, they must proceed immediately to the testing location. Failure to proceed immediately may be deemed a refusal to test.

7. **Reasonable Suspicion Testing**

All safety-sensitive employees must submit to reasonable suspicion drug and/or alcohol testing when a supervisor or company official trained in detecting signs and symptoms of drug use and alcohol misuse has made specific, contemporaneous, articulable observations concerning an employee's appearance, speech, behavior and/or body odor. Reasonable suspicion testing for alcohol misuse will occur when observations are made just before, during, or just after the employee's performance of a safety-sensitive function. Reasonable suspicion testing for prohibited drugs may be conducted anytime an employee is on duty or on standby for duty and a trained supervisor has made the observations.

8. **Post-Accident Testing**

Fatal Accidents: Safety-sensitive employees must submit to post-accident drug and alcohol testing following an accident involving a public transportation vehicle that results in the loss of human life. In addition to a surviving operator of the vehicle, any other surviving, safety-sensitive employee whose performance could have contributed to the accident must also be tested.

Non-Fatal Accidents: All safety-sensitive employees whose actions cannot be completely discounted as a contributing factor must submit to post-accident drug and alcohol testing when a non-fatal accident meets one or more of the following thresholds:

1. An individual suffers bodily injury and immediately receives medical treatment away from the scene
2. One or more vehicles incurs disabling damage that requires the vehicle(s) to be towed away from the accident scene
3. If the public transportation vehicle is a rail car, trolley car, trolley bus or vessel and has been removed from service.

West Ouachita Public Transit officials will use the best information available at the scene, to determine if a safety-sensitive employee's performance can be completely discounted as a contributing factor to the accident.

Post-accident drug and alcohol tests will be conducted as soon as practicable following the accident. Any safety-sensitive employee involved in an accident must refrain from alcohol use for eight (8) hours following the accident or until the employee undergoes a post-accident alcohol test. Any safety-sensitive employee who leaves the scene of the accident without a

justifiable reason or explanation prior to submitting to drug and alcohol testing will be deemed to have refused the test. However, employees are not prohibited from leaving the scene of an accident to obtain assistance in responding to the accident or to obtain necessary emergency medical care.

9. **Urine Specimen Collections**

Urine specimen collections will be conducted in accordance with USDOT rule, 49 CFR Part 40, as amended. Collectors will be appropriately trained and qualified to perform urine specimen collections for USDOT covered employers. Urine specimen collectors will use the split-specimen collection method and will afford the donor (employee) the greatest degree of privacy permitted per 49 CFR Part 40, as amended. When an observed collection is required, the observer will be of the same gender as the donor (employee).

10. **Refusal to Submit to Urine Drug Testing**

The following actions constitute a "refusal to test" in accordance with 49 CFR Part 40, as amended:

- (1) Failure to appear for any test within a reasonable time, as determined by the employer, consistent with applicable DOT agency regulations, after being directed to do so by the employer (pre-employment testing not applicable).
- (2) Failure to remain at the testing site until the testing process is completed (after the process has been started)
- (3) Failure to provide a urine specimen for any drug test required by this part or DOT agency regulations
- (4) In the case of a directly observed or monitored collection in a drug test, fail to permit the observation or monitoring of your provision of a specimen
- (5) Failure to provide a sufficient amount of urine when directed, and it has been determined, through a required medical evaluation, that there was no adequate medical explanation for the failure
- (6) Failure or decline to take an additional drug test the employer or collector has directed you to take
- (7) Failure to undergo a medical examination or evaluation, as directed by the MRO as part of the verification process, or as directed by West Ouachita Public Transit
- (8) Failure to cooperate with any part of the testing process (e.g., refuse to empty pockets when directed by the collector, behave in a confrontational way that disrupts the collection process, fail to wash hands after being directed to do so by the collector).
- (9) For an observed collection, failure to follow the observer's instructions to raise your clothing above the waist, lower clothing and underpants, and to turn around to permit the observer to determine if you have any type of prosthetic or other device that could be used to interfere with the collection process.
- (10) Possessing or wearing a prosthetic or other device that could be used to interfere with the collection process.
- (11) Admitting to the collector or MRO that you adulterated or substituted the specimen.

- (12) When the MRO verifies your drug test result as adulterated or substituted.

Refusing to submit to a USDOT/FTA required test is a violation of the USDOT/FTA testing program. Employees are required to be immediately removed from safety-sensitive duty and provided a list of USDOT-qualified Substance Abuse Professionals.

Per West Ouachita Public Transit authority, violation of the USDOT/FTA testing program will result in termination of employment.

11. **Urine Specimen Analysis**

All specimens will be transported or shipped to a laboratory certified by the Department of Health and Human Services (DHHS). All specimens will be analyzed at the laboratory in accordance with 49 CFR Part 40, as amended. The procedures that will be used to test for the presence of prohibited drugs will protect the employee and the integrity of the drug testing process, safeguard the validity of the test results and ensure that the test results are attributed to the correct employee. Laboratory confirmed drug test results will be released only to a certified Medical Review Officer (MRO) for review and verification.

Negative-Dilute Specimens

Upon receipt of an MRO verified negative-dilute drug test result with creatinine levels greater than 5 mg/dl and less than 20 mg/dl, West Ouachita Public Transit will require applicants and employees to submit to a second urine collection per 49 CFR Part 40.197. The collection of the second specimen will not be conducted using direct observation procedures. The MRO verified result of the second urine drug test will be accepted by West Ouachita Public Transit as the final result and the test of record. ***West Ouachita Public Transit will apply this policy provision uniformly for all pre-employment and random urine drug tests reported by the Medical Review Officer to have creatinine levels greater than 5mg/dl but less than 20mg/dl (negative-dilute results).*** Once notified that a second collection is required, employees must proceed immediately for testing. An employee's failure to report immediately may be deemed as a refusal to submit to testing, which is a violation of the USDOT/FTA testing program. ***Per West Ouachita Public Transit authority, violation of the USDOT/FTA testing program will result in termination of employment.***

12. **Role of the Medical Review Officer (MRO)**

The role of the Medical Review Officer is to review and verify laboratory confirmed test results obtained through a DOT-covered employer's testing program. When a non-negative drug test result is received, the MRO will communicate with the donor (employee) to determine if a legitimate medical explanation exists. When a legally prescribed medication has produced a non-negative result, the MRO will verify the prescription and report the result as "negative" to West Ouachita Public Transit. Medical conditions and other information obtained by the MRO during the interview with the donor will be maintained in a confidential manner. However, if the MRO believes that a medication prescribed to the donor may pose a significant safety risk, the MRO will require the donor to contact his/her prescribing physician and request that the

physician contact the MRO within 5 business days. The MRO and prescribing physician will consult to determine if the employee's medication use presents a significant safety risk. West

Ouachita Public Transit will be notified by the MRO when the outcome of the consultation results in a determination that the donor's medication use presents a significant safety risk. If the employee's prescribing physician fails to respond, the safety concern will be reported to West Ouachita Public Transit without consultation. Based on the MRO recommendation, West

Ouachita Public Transit may deem the employee medically disqualified from performing safety-sensitive functions. The MRO assigned to review and verify laboratory drug test results for West Ouachita Public Transit is:

Michael Brown – St. Francis Medical Center

2600 Tower Drive Suite 304 | Monroe, LA 71201

(318) 966-6324

13. **Consequence for MRO Verified Positive Drug Test**

When West Ouachita Public Transit is notified of an MRO verified positive drug test, or a test refusal due to adulteration or substitution; the violating employee will be immediately removed from safety-sensitive duty and provided a list of DOT-qualified Substance Abuse Professionals. Applicants will be excluded from hire and provided a list of DOT-qualified Substance Abuse Professionals. ***Per West Ouachita Public Transit authority, violation of the USDOT/FTA testing program will result in termination of employment.***

14. **Split Specimen Testing**

As an important employee protection, split specimen collection procedures will be used for all USDOT/FTA urine collections. When an employee challenges an MRO verified result, he/she may request that the split specimen (bottle B) be tested at a different DHHS certified laboratory that conducted the test of the primary specimen (bottle A). Instructions for requesting the split specimen test will be provided by the Medical Review Officer during his/her interview with the donor (employee). In accordance with USDOT rule, West Ouachita Public Transit will ensure that the fee to process the split specimen test is covered, in order for a timely analysis of the split specimen. ***West Ouachita Public Transit may seek reimbursement for the cost of the split specimen test.***

15. **Alcohol Prohibition**

Safety-sensitive employees are prohibited from consuming alcohol while performing safety-sensitive functions, within (4) four hours prior to performing a safety sensitive function, or during the hours that they are on call or standby for duty. No safety-sensitive employee shall report for duty or remain on duty while having an alcohol concentration of 0.02 or greater. Safety-sensitive employees must not consume alcohol within eight (8) hours following an accident or until the employee submits to post-accident testing, whichever occurs first.

16. **Alcohol Testing**

All alcohol screening tests and confirmation tests will be performed in accordance with USDOT rule, 49 CFR Part 40. The procedures that will be used to test for alcohol misuse will protect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure the test results are attributed to the correct employee.

When an alcohol-screening test indicates a blood alcohol concentration (BAC) of 0.02 or greater, a confirmation test will be performed using an evidential breath-testing device listed on the USDOT/ODAPC webpage as an "Approved Evidential Breath Measurement Device". The

confirmed blood alcohol concentration (BAC) result will be transmitted by the technician to West Ouachita Public Transit in a confidential manner. A safety-sensitive employee who has a confirmed blood alcohol concentration (BAC) of 0.02 or greater but less than 0.04 will be removed from safety-sensitive duties for a period of at least (8) eight hours or until test results fall below 0.02.

17. **Consequence for a USDOT/FTA Confirmed Alcohol Violation**

A safety-sensitive employee who has a confirmed blood alcohol concentration (BAC) of 0.04 or greater has violated the USDOT/FTA testing program and will be removed from safety-sensitive duty and provided a list of DOT-qualified Substance Abuse Professionals. **Per West Ouachita Public Transit authority, violation of the USDOT/FTA testing program will result in termination of employment.**

18. **Refusal to Submit to Alcohol Testing**

The following actions constitute a refusal to submit to an alcohol test:

- (1) Fail to appear for any test within a reasonable time, as determined by the employer, consistent with applicable DOT agency regulations, after being directed to do so by the employer.
- (2) Fail to remain at the testing site until the testing process is complete
- (3) Fail to provide an adequate amount of saliva or breath for any USDOT required alcohol test
- (4) Fail to provide a sufficient breath specimen, and the physician has determined, through a required medical evaluation, that there was no adequate medical explanation for the failure
- (5) Fail to undergo a medical examination or evaluation, as directed by the [Agency]
- (6) Fail to sign the certification at Step 2 of the ATF
- (7) Fail to cooperate with any part of the testing process.

Refusing to submit to a USDOT/FTA required test is a violation of USDOT/FTA testing program. Employees must be immediately removed from safety-sensitive duty and provided a list of USDOT-qualified Substance Abuse Professionals. ***Per West Ouachita Public Transit authority, violation of the USDOT/FTA testing program will result in termination of employment.***

19. **West Ouachita Public Transit Testing Program Contacts**

Designated Employer Representative (Drug & Alcohol Program Manager)

Vicki Hilbun/Director of Community Services: vhilbun@westmonroe.la.gov

Davlyn Jones/Manager: djones@westmonroe.la.gov

{318} 397-3299

Further information may be obtained from the USDOT's Office of Drug and Alcohol Policy and Compliance website: <https://www.transportation.gov/odapc> and the Federal Transit Administration's (FTA) website: <https://transit-safety.fta.dot.gov/DrugAndAlcohol/Default.aspx>

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO.

0000001

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.		B. MRO Name, Address, Phone No. and Fax No.	
C. Donor SSN, Employee I.D., or CDL State and No.			
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 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 type="checkbox"/> Other (specify) _____			
G. Collection Site Address:		Collector Contact Info: Phone _____ Fax _____ Other _____	

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☐ URINE☐ ORAL FLUID

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark	
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed	
REMARKS:	

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.		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
<input checked="" type="checkbox"/> Signature of Collector			
(PRINT) Collector's Name (First, MI, Last)		Name of Delivery Service	
Date (Mo/Day/Yr)		Time of Collection	
RECEIVED AT LAB OR IITF:		Primary Specimen Seal Intact	
<input checked="" type="checkbox"/> Signature of Accessioner		<input type="checkbox"/> YES <input type="checkbox"/> NO	
(PRINT) Accessioner's Name (First, MI, Last)		If NO, Enter remark in Step 5A.	
Date (Mo/Day/Yr)		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
Primary/Single Specimen Device Expiration Date: _____		Split Specimen Device Expiration Date: _____	
(Mo/Day/Yr)		(Mo/Day/Yr)	

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

<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DILUTE	<input type="checkbox"/> REJECTED FOR TESTING	<input type="checkbox"/> ADULTERATED	<input type="checkbox"/> SUBSTITUTED	<input type="checkbox"/> INVALID RESULT
<input type="checkbox"/> 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.					
<input checked="" type="checkbox"/> 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		<input type="checkbox"/> RECONFIRMED <input type="checkbox"/> FAILED TO RECONFIRM - REASON _____	
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.	
		<input checked="" type="checkbox"/> Signature of Certifying Scientist	
		(PRINT) Certifying Scientist's Name (First, MI, Last)	
		Date (Mo/Day/Yr)	

	0000001 SPECIMEN A	Date (Mo/Day/Yr)	Donor's Initials	PLACE OVER CAP
	0000001 SPECIMEN B	Date (Mo/Day/Yr)	Donor's Initials	PLACE OVER CAP

COPY 1 - TEST FACILITY COPY

OMB No. 0830-0158

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

0000001

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

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

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

C. Donor SSN, 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 _____

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:

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.

SPECIMEN BOTTLE(S)/TUBE(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 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

(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:

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

OMB No. 0330-0158

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

0000001

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.		B. MRO Name, Address, Phone No. and Fax No.	
C. Donor SSN, Employee I.D., or CDL State and No.			
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 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 type="checkbox"/> Other (specify) _____			
G. Collection Site Address:		Collector Contact Info: Phone _____ Fax _____ Other _____	

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☐ URINE☐ ORAL FLUID

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.			
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark			
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed			
REMARKS:			

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.

<input checked="" type="checkbox"/> Signature of Collector			SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:	
(PRINT) Collector's Name (First, MI, Last)			Name of Delivery Service	
Date (Mo/Day/Yr)			Time of Collection	

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.

<input checked="" type="checkbox"/> 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:

<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____	
<input type="checkbox"/> DILUTE	
<input type="checkbox"/> REFUSAL TO TEST because - check reason(s) below: <input type="checkbox"/> TEST CANCELLED	
<input type="checkbox"/> ADULTERATED (adulterant/reason): _____	
<input type="checkbox"/> SUBSTITUTED	
<input type="checkbox"/> OTHER: _____	

REMARKS:		
<input checked="" type="checkbox"/> 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:

<input type="checkbox"/> RECONFIRMED for: _____		<input type="checkbox"/> TEST CANCELLED	
<input type="checkbox"/> FAILED TO RECONFIRM for: _____			
REMARKS:			
<input checked="" type="checkbox"/> Signature of Medical Review Officer			
(PRINT) Medical Review Officer's Name (First, MI, Last)			
Date (Mo/Day/Yr)			

COPY 3 - COLLECTOR COPY

OMB No. 0930-0168

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

0000001

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.		B. MRO Name, Address, Phone No. and Fax No.	
C. Donor SSN, Employee I.D., or CDL State and No. _____			
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 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 type="checkbox"/> Other (specify) _____			
G. Collection Site Address: _____		Collector Contact Info: Phone _____ Fax _____ Other _____	

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☐ URINE☐ ORAL FLUID

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark	
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed	
REMARKS: _____	

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.

SPECIMEN BOTTLE(S)/TUBE(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 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		(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:

<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____	
<input type="checkbox"/> DILUTE	
<input type="checkbox"/> REFUSAL TO TEST because - check reason(s) below: _____	
<input type="checkbox"/> ADULTERATED (adulterant/reason): _____	<input type="checkbox"/> TEST CANCELLED
<input type="checkbox"/> SUBSTITUTED	
<input type="checkbox"/> 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:

<input type="checkbox"/> RECONFIRMED for: _____		<input type="checkbox"/> TEST CANCELLED
<input type="checkbox"/> 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

OMB No. 0833-0158

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, 5600 Fishers Lane, Room 15E57B, Rockville, Maryland, 20852.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

0000001

ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.		B. MRO Name, Address, Phone No. and Fax No.	
C. Donor SSN, Employee I.D., or CDL State and No.			
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 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, PCR, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____			
G. Collection Site Address:		Collector Contact Info: Phone _____ Fax _____ Other _____	

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

☐ URINE☐ ORAL FLUID

COLLECTION: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark.	
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark <input type="checkbox"/> Observed, Enter Remark	
ORAL FLUID: Split Type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed	
REMARKS:	

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 _____ (PRINT) Collector's Name (First, MI, Last) _____		SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: _____ Name of Delivery Service	
Date (Mo/Day/Yr) _____		Time of Collection _____ AM PM	

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 _____ (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:

<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____	
<input type="checkbox"/> DILUTE	
<input type="checkbox"/> REFUSAL TO TEST because - check reason(s) below:	
<input type="checkbox"/> ADULTERATED (adulterant/reason): _____	
<input type="checkbox"/> SUBSTITUTED	
<input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> TEST CANCELLED	

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:

<input type="checkbox"/> RECONFIRMED for: _____		<input type="checkbox"/> TEST CANCELLED	
<input type="checkbox"/> 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

OMB No. 0930-0158

Privacy Act Statement: (For Federal Employees Only)

Submission of the information on the Federal Drug Testing Custody and Control Form is voluntary. However, incomplete submission of the information, refusal to provide a 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 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, 5600 Fishers Lane, Room 15E57B, Rockville, Maryland, 20852.