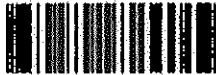


FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM
SPECIMEN ID NO.



2020673279



CLINICAL REFERENCE[®] LABORATORY
8433 QUIVIRA • LENEXA, KANSAS 66215

COMPREHENSIVE CARE

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

88801452-02 MRO2166

A. Employer Name, Address, I.D. No. ACCT: UCC COMP REF1 COMPANY NAME 7501 W 15TH AVE GARY, IN 46406 PH: 219-977-2090		B. MRO Name, Address, Phone and Fax No. DR FRANK MESSANA 7501 W 15TH AVE GARY, IN 46406 PH: 219-977-2090 FX: 219-977-2091	
C. Donor SSN or Employee I.D. No.			
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC <input type="checkbox"/> DOT - 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 Phone No. _____	
		Collector Fax No. _____	

OAS No. 0800-0158

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

Temperature between 90° and 100° F? <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark _____	Collection: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark _____	<input type="checkbox"/> 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:	
<input checked="" type="checkbox"/> Signature of Collector _____ (PRINT) Collector's Name (First, MI, Last)	Date (Mo./Day/Yr.) _____ Time of Collection _____ AM PM	Name of Delivery Service _____	
RECEIVED AT LAB OR IITF:		Primary Specimen Bottle Seal Intact <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, Enter remark in Step 5A.	SPECIMEN BOTTLE(S) RELEASED TO:
<input checked="" type="checkbox"/> Signature of Accessioner _____ (PRINT) Accessioner's Name (First, MI, Last)	Date (Mo./Day/Yr.) _____		

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

<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DILUTE	<input type="checkbox"/> POSITIVE FOR:	<input type="checkbox"/> Marijuana Metabolite (Δ9-THCA)	<input type="checkbox"/> 6-Acetylmorphine	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> MDMA
		<input type="checkbox"/> Cocaine Metabolite (BZE)	<input type="checkbox"/> PCP	<input type="checkbox"/> Morphine	<input type="checkbox"/> Amphetamine	<input type="checkbox"/> MDA
<input type="checkbox"/> REJECTED FOR TESTING	<input type="checkbox"/> ADULTERATED	<input type="checkbox"/> SUBSTITUTED	<input type="checkbox"/> INVALID RESULT	<input type="checkbox"/> Codeine		<input type="checkbox"/> MDEA
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 _____ Laboratory Address _____	<input type="checkbox"/> RECONFIRMED <input type="checkbox"/> 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.
<input checked="" type="checkbox"/> Signature of Certifying Scientist _____ (PRINT) Certifying Scientist's Name (First, MI, Last)	Date (Mo./Day/Yr.) _____



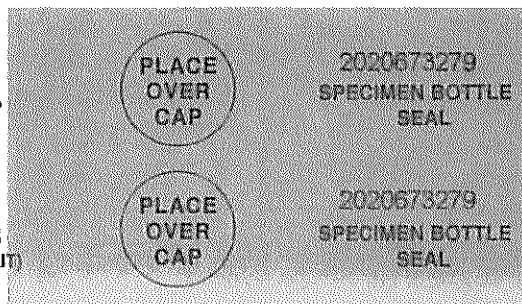
2020673279
SPECIMEN ID NO.

A

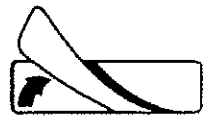


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SPECIMEN ID NO.

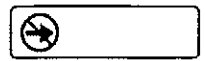
B (SPLIT)



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



Peel on an upward angle across form.



Do not peel directly across form.

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES