FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001 ACCESSION NO.

OMB No. 0930-0158

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 ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Contact Info: Phone _____

Fax _____

Other _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

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

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

SPECIMEN BOTTLE(S)/TUBE(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 Seal Intact ☐ YES ☐ NO If NO, Enter remark in Step 5A.

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

Primary/Single Specimen Device Expiration Date: ____/____/____ **(Mo/Day/Yr)**

Split Specimen Device Expiration Date: ____/____/____ **(Mo/Day/Yr)**

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

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

☐ DILUTE

☐ **POSITIVE** for: _____
Analyte(s) in ng/mL

REMARKS: _____

Test Facility (if different from above) : _____

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable federal requirements.

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

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

_____
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)

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

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

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FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001 ACCESSION NO.

OMB No. 0930-0158

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 ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Contact Info: Phone _____

Fax _____

Other _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90º and 100º F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

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:

☐ **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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FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001 ACCESSION NO.

OMB No. 0930-0158

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 ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Contact Info: Phone _____

Fax _____

Other _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90º and 100º F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

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:

☐ **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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FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 0000001 ACCESSION NO.

OMB No. 0930-0158

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 ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Contact Info: Phone _____

Fax _____

Other _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90º and 100º F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

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

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

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

_____
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: ☐ **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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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.

OMB No. 0930-0158

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 ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

G. Collection Site Address:

Collector Contact Info: Phone _____

Fax _____

Other _____

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ **URINE** ☐ **ORAL FLUID**

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90º and 100º F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Volume Indicator(s) Observed

REMARKS:

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:

☐ **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

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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.