

AADT 12345

Y27813966

LAB USE ONLY

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

SPECIMEN ID NO.

ACCESSION NO.

A. Employer Name, Address, I.D. No.
EMPL NAME: A CUSTOMER, INC.
PHONE: 9095551212 FAX: 9095551213
C/D AMERICAN ALLIANCE DRUG TST 5026241
326 N EUCLID, UPLAND, CA 91786
P: 800-820-9314 F: 909-608-2058

B. MRO Name, Address, Phone No. and Fax No.
BARA RINCK, MD
CENTRAL DRUG SYSTEM, INC
16560 HARBOR BLVD STE A
FOUNTAIN VALLEY, CA 92708
PH 714-418-0130 FX 714-418-0136

C. Donor SSN or Employee I.D. No. [Grid]
 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: [Grid]
 Collector Phone No. [Grid] Collector Fax No. [Grid]

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 57006

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.

Signature of Collector [Grid]
 Time of Collection [Grid] AM PM
 Date (Mo./Day/Yr.) [Grid]

SPECIMEN BOTTLE(S) RELEASED TO:
 Name of Delivery Service Transferring Specimen to Lab
 UPS Local Courier
 Other _____

RECEIVED AT LAB OR IITF:

Signature of Accessioner [Grid]
 (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) 6-Acetylmorphine Methamphetamine MDMA
 Cocaine Metabolite (BZE) Morphine Amphetamine MDA
 PCP Codeine 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.

Signature of Certifying Technician / Scientist [Grid] (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.
 Signature of Certifying Scientist [Grid] (PRINT) Certifying Scientist's Name (First, MI, Last) _____ Date (Mo./Day/Yr.) _____

SPECIMEN ID NO.



Y27813966

SPECIMEN ID NO.

A - SPECIMEN
30 ML



MEDTOX
LABORATORIES, INC.

A-30 ML

Date (Mo. Day. Yr.) _____

Donor's Initials _____

B
SPLIT SPECIMEN
15 ML



MEDTOX
LABORATORIES, INC.

B-15 ML

Date (Mo. Day. Yr.) _____

Donor's Initials _____

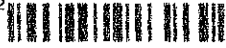
NON-REGULATED 5 PART DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO.

223758891



402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244



A A D T

STEP 1

To be completed by COLLECTOR or EMPLOYER REPRESENTATIVE Account # 502624

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

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

LAB ACCESSION NO.

EMPL NAME: C/O AMERICAN ALLIANCE DRUG TST
PHONE: 326 N EUCLID, UPLAND, CA 91786
FAX: P: 800-820-9314 F: 909-608-2058

SARA RINCK, MD
CENTRAL DRUG SYSTEM, INC
16560 HARBOR BLVD STE A
FOUNTAIN VALLEY, CA 92708
PH 714-418-0130 FX 714-418-0136

Account # 502624

Donor I.D.

C. Donor Name (Last, First)

Donor Daytime Phone

D. Reason for Test: Pre-employment, Random, Reasonable Suspicion/Cause, Return To Duty, Follow-up, Post Accident, Other (Specify)

E. Collection Site Name, Collector Phone No., Collector Fax No.

F. Test(s) Ordered: 88365 5 PANEL, OTHER TEST CODE:

STEP 2: COMPLETED BY COLLECTOR. Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? Yes No, Enter Remark

Specimen Collection: Split Single None Provided (Enter Remark) Observed (Enter Remark) 14008

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 LABORATORY

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 requirements.

X Signature of Collector (PRINT) Collector's Name (First, MI, Last)

Time of Collection AM PM Date (Mo./Day/Yr.)

SPECIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab UPS Local Courier Other

RECEIVED AT LAB: X Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last) Date (Mo./Day/Yr.)

SPECIMEN BOTTLE(S) RELEASED TO: Primary Specimen Bottle Seal Intact Yes No, Enter Remark Below

Empty grid for specimen tracking



SPECIMEN ID NO.

A - SPECIMEN 30 ML



A-30 ML

Date (Mo. Day. Yr.)

Donor's Initials

B SPLIT SPECIMEN 15 ML



B-15 ML

Date (Mo. Day. Yr.)

Donor's Initials

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