

ORDER FOR TESTING

To be completed by collection site personnel upon arrival at site and returned to employer with Employer's copy of Chain of Custody Form.

Time _____ Date _____ Collection Site Personnel Initials _____

Print Collection Site Personnel Name _____

The Federal Transit Administration issued regulations (49 CFR Part 655) that require all safety-sensitive employees/applicants to submit to drug and alcohol testing as a condition of employment in a safety-sensitive position. Refusing to submit to testing; adulterating, substituting, or tampering with the specimen; or failing to cooperate with any part of the collection process is a violation of the regulations and of company policy.

Testing is to be accomplished on the date, time and location indicated below. **You must present this form at the collection site.**

Print Full Name: _____ ID # _____

Collection Site Location: _____

Time Notified: _____ on _____ (date)

Failure to complete a drug and/or alcohol test will be considered a test refusal.

* **Pre-employment tests** = New applicants, transfer from a non-safety-sensitive position, return to active status.

** **Return-to-Duty tests** = Only performed following a positive/refusal to test and successful completion of SAP counseling.

Type of Test: ☐ Drug ☐ Alcohol ☐ Both

Test Authority: ☐ DOT-FTA ☐ Non-DOT ☐ DOT- Other _____

Test Category: ☐ Pre-employment* ☐ Random

☐ Post-accident ☐ Reasonable Suspicion

☐ Return-to-duty** ☐ Follow-up

☐ Retest, Specify: _____

Observed Collection: ☐ Yes ☐ No

Transported: ☐ Yes, By Whom: _____ ☐ No

Picture ID: ☐ Yes ☐ No

Other Special Instructions: _____

Supervisor Authorizing Test: _____
Print Name Date

Designated Employer Representative / DAPM: _____
Print Name Phone Number

**Acknowledgement of Prohibited Drug Awareness Training
For Safety-Sensitive Employees**

In accordance with Federal Transit Administration (FTA) Rule 49 CFR Part 655.14(b), I acknowledge that I have received at least 60 minutes of training on the effects and consequences of prohibited drug use on personal health, safety, and the work environment, and on the signs and symptoms that may indicate prohibited drug use.

(Print Name)

(Signature)

(Date)

PRE-EMPLOYMENT DRUG TESTING ACKNOWLEDGEMENT

I, hereby acknowledge and understand that, as part of my application for employment for a position which involves the performance of safety-sensitive functions as defined by 49 CFR Part 655, as amended, I must submit to a drug test under the authority of the U.S. Department of Transportation, Federal Transit Administration. I acknowledge and understand that my employment is contingent on the passing of the aforementioned drug test, and I will not be assigned to perform a safety-sensitive function unless my drug test has a verified negative result.

Signature of Applicant

Date

Print Name

Date

(Your application will not be considered for employment of a covered safety-sensitive position unless this acknowledgment is completed and signed.)

PRE-EMPLOYMENT DRUG & ALCOHOL TESTING ACKNOWLEDGEMENT

I hereby acknowledge and understand that, as part of my application for employment for a position which involves the performance of safety-sensitive functions as defined by 49 CFR Part 655, as amended, I must submit to a drug test and alcohol test under the authority of the U.S. Department of Transportation, Federal Transit Administration. I acknowledge and understand that my employment is contingent on the passing of the aforementioned drug and alcohol test, and I will not be assigned to perform a safety-sensitive function unless my drug test has a verified negative result and my alcohol test result is below 0.02.

Signature of Applicant

Date

Print Name

Date

(Your application will not be considered for employment of a covered safety-sensitive position unless this acknowledgment is completed and signed.)

**ACKNOWLEDGEMENT
OF
EMPLOYER'S DRUG AND ALCOHOL TESTING POLICY**

I, _____, the undersigned, hereby
Print Full Name

acknowledge that I have received a copy of the anti-drug and alcohol misuse program policy mandated by the U.S. Department of Transportation, Federal Transit Administration for all covered employees who perform a safety-sensitive function. I understand this policy is required by 49 CFR Part 655, as amended, and has been duly adopted by the governing board of the employer. Any provisions contained herein which are not required by 49 CFR Part 655, as amended, that have been imposed solely on the authority of the employer are designated as such in the policy document.

I further understand that receipt of this policy constitutes a legal notification of the contents, and that it is my responsibility to become familiar with and adhere to all provisions contained therein. I will seek and get clarification for any questions concerning the provisions contained in the policy. I also understand that compliance with all provisions contained in the policy is a condition of employment.

I further understand that the information contained in the approved policy dated _____, is subject to change, and that any such changes, or addendum, shall be disseminated in a manner consistent with the provision of 49 CFR Part 655, as amended.

Signature of Employee

Date

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SAFETY-SENSITIVE EMPLOYEE APPLICATION SUPPLEMENT

Previous US Department of Transportation Drug and Alcohol Testing

Applicant First Name, Middle Initial, Last Name

Social Security Number

Have you ever participated in USDOT-regulated drug and alcohol testing with previous employers?

Yes_____ (if yes, complete #1 and #2)

No_____ (if no, skip to #2)

1. In the last two years, have you ever:

a) Tested positive (0.04 or greater) for alcohol?

Yes_____

No_____

b) Had a verified positive drug test result?

Yes_____

No_____

c) Refused a required drug or alcohol test (or had a verified adulterated or substituted drug test result)?

Yes_____

No_____

d) Violated any other DOT drug or alcohol testing regulation within the last two years?

Yes_____

No_____

2. Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules in the last two years?

Yes_____

No_____

If you responded "YES" to any of the above questions, please provide documentation or your successful completion of DOT return-to-duty requirements. If you do not have this information, please explain why: _____

(Use additional pages as necessary)

"I certify that the facts contained in this form are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this form shall be grounds for dismissal."

Signed

Date

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AUTHORIZATION FOR RELEASE OF INFORMATION FROM PREVIOUS EMPLOYER ON US DOT DRUG AND ALCOHOL TESTING

(A **separate form** must be filled out for each US DOT-regulated employer who employed the applicant during the two-year period preceding the date of the employee's application or transfer)

I, _____, authorize that:
Print First Name, Middle Initial, Last Name Last 4 digits of Social Security Number

Contact Person: _____

Previous Employer: _____

Street Address or
P.O. Box: _____ Telephone: _____

City, State, Zip _____ Fax: _____

may release the information requested below concerning my US DOT drug and alcohol testing records to:

Contact Person: _____

Prospective Employer: _____

Street Address or
P.O. Box: _____ Telephone: _____

City, State, Zip _____ Fax: _____

Applicant's Signature

Date

This information will be used solely for the purpose of ascertaining whether I am eligible to perform safety-sensitive functions for the _____. This authorization for release of information is valid for one year from the date of signature.

COMPLETED BY PREVIOUS EMPLOYER

Check here ☐ if this employee did **not** participate in US DOT-regulated drug and alcohol testing while under your employment. Then sign below and return this form;
OR, respond to the following questions regarding this employee's US DOT-regulated drug and alcohol testing history while employed with your agency/firm.

- | | |
|--|---------------|
| 1. Has this employee tested positive (0.04 or greater) for alcohol in the last two years? | Y ____ N ____ |
| 2. Has this employee had a verified positive drug test result in the last two years? | Y ____ N ____ |
| 3. Has this employee refused a required drug or alcohol test in the last two years? | Y ____ N ____ |
| 4. Has this employee violated any other US DOT drug or alcohol testing regulation within the last two years? | Y ____ N ____ |
| 5. Has a previous employer reported a drug and alcohol rule violation to you? | Y ____ N ____ |
| 6. If you answered yes to any of the above items, did the employee complete the return to duty process? | Y ____ N ____ |

Note: If you answered "yes" to item 5, you must provide the previous employer's report. If you answered "yes" to item 6, you must also transmit the appropriate return-to-duty documentation (e.g. SAP report(s), follow-up testing record).

Previous Employer's Signature

Date

Please return this form to the prospective employer at the address listed above.

‘GOOD FAITH EFFORT’ DOCUMENTATION

Release of Information from Previous Employer on DOT Drug and Alcohol Testing

1. _____'s first attempt at acquiring information from previous
_____ Agency Name
employer on DOT drug and alcohol testing, for _____,
Employee's Full Name
was performed on _____.
Date Agency Name sent an
'authorization for release' form, through certified mail, to the following DOT Employer:

Previous Employer's Address (add additional sheets for additional employers)

2. _____'s second attempt at acquiring information from previous employer
Agency Name
on DOT drug and alcohol testing, for the aforementioned employee, was performed on_____.
Date
_____attempted to call the previous employer at the following
Agency Name
telephone numbers:

Employer's Name and Telephone Number (add additional sheets for additional employers)

☐ Left Voice-Mail Message ☐ Successfully Reached Company Representative
(Check appropriate box)

3. _____'s third attempt at acquiring information from previous employer
Agency Name
on DOT drug and alcohol testing, for the aforementioned employee, was performed on_____.
Date

Agency Name attempted to call the previous employer at the following
telephone numbers:

Employer's Name and Telephone Number (add additional sheets for additional employers)

☐ Left Voice-Mail Message ☐ Successfully reached Company Representative
(Check appropriate box)

POST ACCIDENT TESTING DECISION REPORT

A separate sheet must be filled out for each covered employee that contributed to the accident

System Name: _____ Date of Accident: _____

Time of Accident: _____ Time Employer was notified: _____

Location of Accident: _____

Safety-Sensitive Employee: _____ Position: _____
i.e. Driver, Dispatcher, etc.

1. Did the accident involve a public transit vehicle? ☐ Yes ☐ No
2. Did the accident involve the operation of the vehicle? ☐ Yes ☐ No
3. Was there loss of life as a result of the accident? * ☐ Yes ☐ No
4. Did an individual suffer a bodily injury and immediately receive medical treatment away from the scene? * ☐ Yes ☐ No
5. Was there disabling damage to any of the involved vehicles? * ☐ Yes ☐ No
6. a) Did you perform a drug and/or alcohol test?
(Use Decision Tree on back of this form) ☐ Yes ☐ DOT-FTA Authority ☐ Yes (NON-DOT) ☐ Company Authority ☐ No
- b) If no, why not? _____
- c) For a non-fatal accident, can the covered employee(s) performance be completely discounted as a contributing factor to the accident? ☐ Yes ☐ No
7. a) Was an alcohol test performed within 2 hours? ☐ N/A ☐ Yes ☐ No
- b) If no, why: _____
8. If no alcohol test occurred, and more than 8 hours elapsed from the time of the accident, please explain: _____

9. a) Was a drug test performed within 32 hours? ☐ N/A ☐ Yes ☐ No

b) If no, why: _____

10. a) Did the employee leave the scene of the accident without a reasonable explanation? ☐ Yes ☐ No

b) If Yes, please explain: _____

Test Determination:

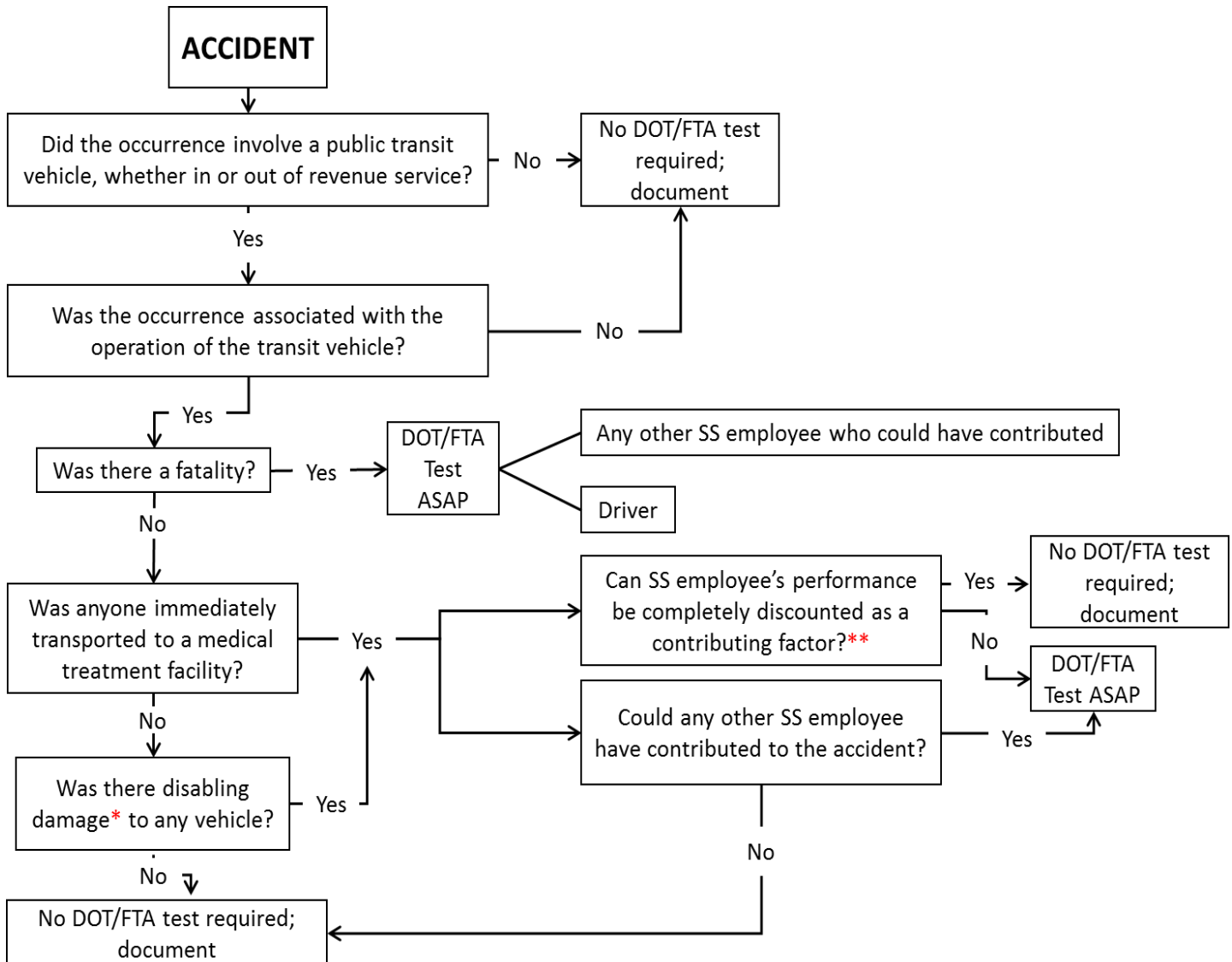
Name of supervisor making determination: _____

Time employee was informed of determination: _____

Signature & Title _____

Date _____

Post Accident Decision Tree



*** Disabling Damage:** Damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repairs.

(1) **Inclusion:** Damage to a motor vehicle, where the vehicle could have been driven, but would have been further damaged if so driven.

(2) **Exclusions:**

A. Damage that can be remedied temporarily at the scene of the accident without special tools or parts.

B. Tire replacement without other damage even if no spare tire is available.

C. Headlamp or tail light damage.

D. Damage to turn signals, horn, or windshield wiper, which makes the vehicle inoperable.

**** Contributing Factor:** The determination of whether or not a safety-sensitive employee's performance was a contributing factor should be the decision of the company official investigating the accident; not based on the police officer's accident fault determination. This decision should not be made hastily. The company official's determination must be based on the best available information at the time of the accident.

REASONABLE SUSPICION INCIDENT CHECKLIST

Employee's Full Name

Date / Time of Observation

Supervisor's Full Name & Telephone

Date of Supervisor's Reasonable Suspicion Decision Training

This checklist is to be completed when a supervisor – trained in accordance with USDOT Agency regulations for reasonable suspicion/cause determination requirements – determines that an incident has occurred which provides reasonable suspicion that an employee is exhibiting behaviors consistent with the symptoms of drug use and / or alcohol misuse. Mark each applicable item on this form and add any additional facts or circumstances which you have observed.

A. Nature of Incident / Cause for Suspicion

- ☐ 1. Observed/reported possession or use of a prohibited substance (including passenger complaint).
- ☐ 2. Apparent drug or alcohol intoxication.
- ☐ 3. Observed drug or alcohol intoxication.
- ☐ 4. Arrest for drug-related offense
- ☐ 5. Other, Please specify:

B. Behavioral Indicators

- ☐ 1. Verbal abusiveness
- ☐ 2. Physical abusiveness
- ☐ 3. Extreme aggressiveness or agitation
- ☐ 4. Withdrawal, depression, tearfulness, or responsiveness
- ☐ 5. Inappropriate verbal responses to questioning or instruction
- ☐ 6. Other erratic or inappropriate behavior (e.g. hallucinations, disoriented, confused) Please specify:

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C. Physical Signs and Symptoms

- ___1. Possession, dispensing, or using prohibited substance
 - ___2. Slurred or incoherent speech
 - ___3. Unsteady gait or other loss of physical control, poor conditioning
 - ___4. Dilated or constricted pupils or unusual eye movement
 - ___5. Bloodshot or watery eyes
 - ___6. Extreme aggressiveness or agitation
 - ___7. Excessive sweating or clamminess of skin
 - ___8. Flushed or very pale face
 - ___9. Highly excited or nervous
 - ___10. Nausea or vomiting
 - ___11. Disheveled appearance or out of uniform
 - ___12. Odor of alcohol
 - ___13. Odor of Marijuana
 - ___14. Dry mouth (frequent swallowing/lip wetting)
 - ___15. Shaking hands or body tremors/twitching
 - ___16. Dizziness or fainting
 - ___17. Breathing irregularity or difficulty breathing
 - ___18. Runny nose or sores around nostrils
 - ___19. Inappropriate wearing of sunglasses
 - ___20. Puncture marks or "tracks"
 - ___21. Other (Specify) _____
- _____
- _____
- _____

D. Written Summary

Please summarize the facts and circumstances surrounding the incident. The observations must be specific, contemporaneous, and articulable regarding the appearance, behavior, speech, or body odors of the safety-sensitive employee. Attach additional sheets as needed.

The above document of physical, behavioral, and performance indicators of the named employee were observed by:

Supervisor's Full Name

Signature

Date

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**SUBSTANCE ABUSE PROFESSIONAL REFERRAL
EMPLOYEE NOT PRESENT**

*If the employee **is not present** to sign the Substance Abuse Professional Referral letter, send this form to the employee utilizing **certified mail**.*

Employee/Applicant Full Name: _____

Employee/Applicant Identification Number: _____

This letter serves to notify that the aforementioned individual was in violation of DOT drug and alcohol regulations (49 CFR Part 655 and/or 40) on _____. In accordance
Date
with 49 CFR Part 655.62, this agency is required to advise the individual of the resources available for evaluating and resolving problems associated with prohibited drug use and/or alcohol misuse.

The following Substance Abuse Professional(s) is available for the individual:

Name: _____

Address: _____

City/State: _____

Phone: _____

Alternate Substance Abuse Professional Referral:

Name: _____

Address: _____

City/State: _____

Phone: _____

Agency Representative Full Name, Title

Telephone Number

Agency Name

Agency Representative Signature

Date

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SUBSTANCE ABUSE PROFESSIONAL REFERRAL

I acknowledge that I have received a referral to a Substance Abuse Professional in accordance with 49 CFR Part 655.62.

The cost of this service will be paid by: _____.

Substance Abuse Professional Referral:

Name: _____

Address: _____

City/State: _____

Phone: _____

Alternate Substance Abuse Professional Referral:

Name: _____

Address: _____

City/State: _____

Phone: _____

I, _____, have received a copy of this referral.
Employee/Applicant Full Name

Employee/Applicant Signature

Date

Agency Representative Full Name, Title

Telephone Number

Agency Name

Agency Representative Signature

Date

COLLECTION SITE “MOCK COLLECTION” CHECKLIST

Name of Collection Site: _____ Date of Review: _____

Name of Collector: _____ Name of Reviewer: _____

UNEVENTFUL BREATH ALCOHOL TEST (result less than 0.02) - Did the Breath Alcohol Technician (BAT)...

- ☐ Require employee to provide positive photo identification (Part 40.241(c)).
- ☐ Perform the Alcohol test before the drug test, if applicable
- ☐ Explain testing procedures on back of Alcohol Testing Form (ATF) (40.241(e))
- ☐ Complete Step 1 of ATF (40.241(f))
 - Employee Name, ID Number
 - Employer Name and Contact information
 - DER Name and Telephone Number
 - Reason for Test
- ☐ Have the employee complete Step 2 of the ATF (40.241(g))
- ☐ Open individually sealed mouthpiece and attach to EBT (40.243(b))
- ☐ Instruct employee to blow forcefully until EBT indicates that an adequate amount of breath has been obtained (40.243(c))
- ☐ Show employee the result displayed on EBT (40.243(d))
- ☐ If EBT prints result on paper strip: Did the BAT affix the strip to the ATF using tamper evident tape (40.243(f))
- ☐ If EBT does not print results on paper strip: Did the BAT complete the following information on Step 3 of the ATF (40.243(g)):
 - Identification of the machine
 - Time
 - Sequential Test Number
 - Test Outcome
- ☐ Complete Step 3 of the ATF by dating and signing the certification (40.247(a))
- ☐ Distribute the ATF copies to appropriate individuals (40.247(a)):
 - Copy 1 to Employer
 - Copy 2 to Employee
 - Retain Copy 3

After the Breath Alcohol Test is completed, review the following items:

- ☐ Was consent - giving the collection site or its personnel indemnification - required for testing? (40.355(a))
 - Collection sites cannot require an employee to sign a consent, release, waiver of liability, or indemnification agreement with respect to any part of the alcohol or drug testing process covered by 49 CFR Part 40. No one may do so on behalf of a service agent.

- ☐ Is the EBT listed on the USDOT-ODAPC Website for “Approved Evidential Breath Measurement Devices”? <https://www.transportation.gov/odapc/Approved-Evidential-Breath-Measurement-Devices>
- ☐ Was the correct ATF used? (40.225(a))
 - The DOT ATF must be used for every DOT alcohol test. The ATF must be a three-part carbonless manifold form. The ATF is found in Appendix G of 49 CFR Part 40. You may view this form on the ODAPC website (www.transportation.gov/odapc)
- ☐ Were all necessary equipment, personnel, and materials for breath testing provided at the location where testing occurred? (40.221(d))
- ☐ Did the breath alcohol testing location afford visual and aural privacy to prevent unauthorized persons from seeing or hearing test results? (40.221(c))
- ☐ Did the BAT remain with the employee for the entire duration of the alcohol testing procedure? (40.223(e)(3))
- ☐ Does the BAT have a copy of the quality assurance plan (QAP) for the EBT? (40.233(c))
- ☐ Ask to see the external calibration checks for the EBT (40.233(c))
- ☐ Have the BATs completed the required training and acquired the proper credentials? (40.213(g))
- ☐ Ask to see the credentials of the BAT
- ☐ Does the BAT have a current copy of 49 CFR Part 40? (40.213)
- ☐ Is the BAT signed-up for the USDOT-ODAPC List-Serv?

UNEVENTFUL URINE COLLECTION - Did the Collector...

- ☐ Require employee to provide positive identification (Part 40.61(c)).
- ☐ Direct the employee to remove outer clothing (jacket, hat) and to leave these garments and other personal items (briefcase, purse, etc.) in a mutually agreeable location (Part 40.61(f)).
 - Advises employee that failure to comply constitutes a refusal to test.
 - Allows employee to keep wallet, if requested (40.61(f)(2)).
- ☐ Direct employee to empty pockets and display items in them (Part 40.61(f)(4)).
 - If no potential adulterants are found, allow employee to return items to pockets.
- ☐ Complete Step 1 of CCF (Part 40.63(a)).
 - Ensures that the name and address of the drug testing laboratory appears at the top of the CCF.
 - Ensures that the Specimen ID at the top of the CCF matches the Specimen ID on labels/seals.
 - Checks the Reason for Test box (Pre-Employment, Random, Post-Accident, etc.).

- Checks the FTA box (Testing Authority)
 - Checks the Drug Tests to Be Performed box (THC, COC, PCP, OPI, AMP for DOT).
 - ☐ Instruct employee to wash/dry hands and not to wash hands again until delivering specimen to collector (Part 40.63(b)).
 - ☐ Ensure collection container is selected and unwrapped in presence of employee (Part 40.63(c)).
 - ☐ Secure urination facility before the collection (If single-toilet room with a full-length privacy door) (Parts 40.41 & 43).
 - Secures any water sources or make them unavailable to employees (e.g., turn off water inlet, tape handles to prevent opening faucets).
 - Ensures that the water in the toilet bowl contains bluing agent.
 - Ensures that soap, disinfectants, cleaning agents, or other possible adulterants are not present.
 - Inspects the site to ensure that no foreign or unauthorized substances are present.
 - Tapes or otherwise securely shuts any movable toilet tank or puts bluing agent in the tank.
 - Ensures that undetected access (e.g., through a door not in your view) is not possible.
 - Secures areas and items (e.g., ledges, trash receptacles, paper-towel holders, under-sink areas, drop-down ceiling panels) that appear suitable for concealing contaminants.
 - ☐ Direct employee to go into room used for urination and instruct employee to:
 - Provide at least 45 ml of urine.
 - Not flush the toilet.
 - Return specimen to the collector as soon as the void is complete.
 - Set a reasonable time limit for voiding (Part 40.63(d)(2)).
 - Allow only the employee into the room used for urination (40.41(d)(1)).
 - ☐ Check that the specimen:
 - Contains at least 45 ml of urine. If not, follow shy bladder procedure (Part 40.65(a)).
 - Reads temperature strip within 4 minutes (Part 40.65(b)).
 - ☐ Mark appropriate box in Step 2 of CCF (Yes = from 90 to 100 degrees).
 - ☐ Check specimen for signs of tampering (Part 40.65).
 - ☐ Check specimen for unusual color, foreign objects/material, or other signs of tampering (odor).
 - ☐ Mark box in Step 2 of the CCF indicating a split specimen collection (Part 40.71(b)(1)).
 - ☐ Pour at least 30 ml of urine into the primary specimen bottle (Part 40.71(b)(2)).
 - ☐ Pour at least 15 ml of urine into the secondary specimen bottle (Part 40.71(b)(2)).
 - ☐ Secure the lids or caps on the specimen bottles (Part 40.71(b)(4)).
 - ☐ Place the tamper-evident seals on the specimen bottles (Part 40.71(b)(5)).
 - Dates the specimen bottle seals (Part 40.71(b)(6)).
 - Ensures that the employee initials specimen bottle seals (Part 40.71(b)(7)).
 - ☐ Direct employee to read and sign certification statement on Copy 2, Step 5 of CCF and to provide date of birth, printed name, day and evening contact telephone numbers (Part 40.71(a)(1)).
 - ☐ Print collector name in Copy 1, Step 4 of CCF; record the date and time of collection; sign statement; enter actual name of delivery service transferring the specimen to laboratory (Part 40.73(a)(2)).
 - ☐ Ensure that all copies of the CCF are legible and complete (Part 40.73(a)(3)).
 - ☐ Remove Copy 5 of the CCF and give it to the employee (Part 40.73(a)(4)).
 - ☐ Place specimen bottles and Copy 1 of CCF in plastic bag and secure both pouches of plastic bag (Part 40.73(a)(5)-(a)(6)).
 - ☐ Advise employee that he/she may leave the site (Part 40.73(a)(7)).
 - ☐ Recheck the urination facility, performing all steps as was done prior to the collection to ensure the site's continued integrity.
- After the Urine Collection is completed, review the following items:**
- ☐ Was the correct CCF used?
 - The Federal CCF must be used for all USDOT collections (40.45(a))
<https://www.samhsa.gov/sites/default/files/workplace/2020-fed-ccf-proof.pdf>
 - ☐ Ask to see the location where the urine specimens are maintained until they are picked-up by the courier. Is this location secure?
 - ☐ Does the collector have ready access to the most recent version of the Urine Specimen Collection Guidelines published by USDOT-ODAPC?
 - ☐ Does the collector have ready access to the most recent version of 49 CFR Part 40?
 - ☐ Ask to see the training credentials for the collector to show they meet the requirements of 49 CFR Part 40.33
 - ☐ Is the collector signed-up for the USDOT-ODAPC List-Serv?

POSITIVE DRUG AND ALCOHOL TESTING LOG

Employee	Date/Time of Positive Result	Type of Violation	SAP Referral	Outcome	Transferred all documentation to this folder?	
		<input type="checkbox"/> Positive <input type="checkbox"/> Refusal <input type="checkbox"/> Other:		<input type="checkbox"/> Termination <input type="checkbox"/> Counseling <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Positive <input type="checkbox"/> Refusal <input type="checkbox"/> Other:		<input type="checkbox"/> Termination <input type="checkbox"/> Counseling <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Positive <input type="checkbox"/> Refusal <input type="checkbox"/> Other:		<input type="checkbox"/> Termination <input type="checkbox"/> Counseling <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Positive <input type="checkbox"/> Refusal <input type="checkbox"/> Other:		<input type="checkbox"/> Termination <input type="checkbox"/> Counseling <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial

POST-ACCIDENT TESTING LOG

Employee	Date/Time of Accident	Accident Result	Date/Time of Test	Date/Time of Test Result	Transferred all documentation to folder?	
		<input type="checkbox"/> Fatality <input type="checkbox"/> Immediate Transport to Medical Facility <input type="checkbox"/> Disabling Damage <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Fatality <input type="checkbox"/> Immediate Transport to Medical Facility <input type="checkbox"/> Disabling Damage <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Fatality <input type="checkbox"/> Immediate Transport to Medical Facility <input type="checkbox"/> Disabling Damage <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Fatality <input type="checkbox"/> Immediate Transport to Medical Facility <input type="checkbox"/> Disabling Damage <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
		<input type="checkbox"/> Fatality <input type="checkbox"/> Immediate Transport to Medical Facility <input type="checkbox"/> Disabling Damage <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial

PRE-EMPLOYMENT TESTING LOG

Employee	Testing Acknowledgement	Safety-Sensitive Application Supplement	Previous Employer Record Check	Policy Acknowledgement	Order for Test	Date/ Time of Test	Date/ Time of Result	Hire Date	Date Began Safety-Sensitive Functions
	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:		
	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:		
	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:		
	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:	<input type="checkbox"/> Complete <input type="checkbox"/> Pending:		

RANDOM TESTING LOG

Employee	Random Selection Sheet	Order For Test	Date/Time of Test	Test Day	Date/Time of Result	Transferred all documentation to folder?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial

REASONABLE SUSPICION TESTING LOG

Employee	Date/Time of Suspicion	Date/Time of Test	Date/Time of Test Result	Reasonable Suspicion Incident Check List?	Transferred all documentation to this folder?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:

RETURN-TO-DUTY / FOLLOW-UP TESTING LOG

Employee Name	Order For Test	Return to Duty Release	Follow-up Test Plan	Date/Time of Test	Consistent with SAP's Follow Up Plan?	Test Result & Date	Notes
Return to Duty Test		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Follow-up Test*		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		

* The SAP determines the number of Follow-up tests (minimum of 6 tests in the first 12 months). This information will be included in the Follow-up testing plan.

VENDOR OVERSIGHT INSPECTION MASTER LOG

Site Name	Date of Interview	Compliant?	Follow up for non-compliant area(s)	Date of error(s) correction	Comments	Initials
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			

Designated Employer Representative (DER) Contact Report

Private and Confidential

Donor Name: _____ **ID Number:** _____

Donor Contact Phone Number(s) from CCF: _____

MRO Name: _____ **Contact Number:** _____

Date of MRO Notification: _____ **Time of MRO Notification:** _____

DER Contact Attempts:

<u>Date</u>	<u>Time</u>	<u>Phone Number</u>	<u>Outcome</u>

49 CFR PART 40.131(d) As the DER, you must attempt to contact the employee immediately, using procedures that protect, as much as possible, the confidentiality of the MRO's request that the employee contact the MRO. If you successfully contact the employee (i.e., actually talk to the employee), you must document the date and time of the contact, and inform the MRO. You must inform the employee that he or she should contact the MRO immediately. You must also inform the employee of the consequences of failing to contact the MRO within the next 72 hours (see §40.133(a)(2)).

(1) As the DER, you must not inform anyone else working for the employer that you are seeking to contact the employee on behalf of the MRO.

(2) If, as the DER, you have made all reasonable efforts to contact the employee but failed to do so, you may place the employee on temporary medically unqualified status or medical leave. Reasonable efforts include, as a minimum, three attempts, spaced reasonably over a 24-hour period, to reach the employee at the day and evening telephone numbers listed on the CCF. (Emphasis added)

(i) As the DER, you must document the dates and times of these efforts.

(ii) If, as the DER, you are unable to contact the employee within this 24-hour period, you must leave a message for the employee by any practicable means (e.g., voice mail, e-mail, letter) to contact the MRO and inform the MRO of the date and time of this attempted contact.

Drug Testing Custody and Control Form (CCF) Review Checklist

- Does the form read “Federal Drug Testing Custody and Control Form” at the top?
- **In Step 1:**
 - ☐ Is the correct employer name, DER Name, DER phone number and employer address listed? (The employer’s name must be listed here, not the C/TPA. Additionally, the DER's Name and Contact information must be listed)
 - ☐ Is the correct MRO’s name, address, phone, and fax number listed?
 - ☐ Is the correct employee ID number or SSN listed?
 - ☐ Is the FTA box marked?
 - ☐ Is the reason for the test marked correctly?
 - ☐ Is the box indicating this is a five-panel test marked?
 - ☐ Is the collection site address indicating the location where the test was actually performed and the site’s telephone numbers completed accurately?
- **In Step 2:**
 - ☐ Is the "URINE" box checked
 - ☐ Is the Temperature between 90° and 100°F marked (‘Yes’ or ‘No, Enter Remark’)?
 - ☐ Is the “Split” collection box marked?
 - ☐ If it was an observed collection, is the “Observed” box marked? (This box should not be marked if an observed collection was not performed.)
 - ☐ Is there an appropriate comment included in the Remarks Section? The most common need for remarks include: Temperature Out of Range; Insufficient Volume; Adulteration; and Employee Refuses to Sign.
- **In Step 3:**
 - ☐ Even though there is no information provided in Step 3 of the form, look at the bottom of the CCF in the Step 7 portion of the Employer’s copy for a faint shadow, imprint, or traces of carbon ink of a date or the employee’s initials.
 - During the collection process, the collector dates, and the employee initials, the bottles seals **after** they have been affixed to the bottles. Carbon shadows in Step 7 indicate the date and/or initials were written on the bottle seals **before** they were affixed to the bottles. **This practice is unacceptable.**
- **In Step 4:**
 - ☐ Has the collector printed their name and signed?
 - ☐ Is the time and date correct? Make sure the appropriate AM or PM time is indicated. (If an alcohol test was also performed, compare the time on the ATF with the time on the CCF to make sure the alcohol test was completed first.)
 - ☐ Is the delivery service name clearly identified in the “Specimen Bottles Released To” box?
- **In Step 5:**
 - ☐ Are the employee’s name, telephone number(s), and date of birth provided?
 - ☐ Is the date of collection provided?
 - ☐ Did the employee sign the form? If not, is this documented in the Remarks Section of Step 2?

AFFIDAVIT OF CORRECTION

According to 49 CFR Part 40, as amended, **the collector of the drug test referenced below** must take all practicable action to correct errors on the Federal Drug Testing Custody and Control Form so that the test is not cancelled.

Transit System Name: _____ Date of Test: _____

Test Category: _____ Specimen ID#: _____

Donor Name: _____ Collector Name: _____

Date Collector Was Notified of Error: _____

This affidavit addresses the following errors that were not performed in accordance with 49 CFR Part 40, as amended:

Step 1 Requirements (§40.63) (check all that apply)

- ☐ A. Missing/Incorrect Employer Name, Address, Phone, and Fax
- ☐ B. Missing/Incorrect MRO Name, Address, Phone and Fax No.
- ☐ C. Missing Donor SSN or Employee I.D. No.
- ☐ D. Missing/Incorrect Testing Authority
- ☐ E. Missing/Incorrect Reason for Test
- ☐ F. Missing/Incorrect Drug Tests to be Performed
- ☐ G. Missing/Incorrect Collection Site Name, Address, Phone and Fax No.

Step 2 Requirements (§40.65-70) (check all that apply)

- ☐ Collector failed to mark the "urine" box
- ☐ Collector failed to indicate if the specimen was within the acceptable temperature range
- ☐ Collector failed to mark 'Split'
- ☐ Collector arbitrarily marked 'Observed'
- ☐ Collector failed to mark 'Observed'
- ☐ Missing explanation within 'Remarks' section. (i.e. any unusual circumstances that occur during collection)

Step 3 Requirements (§40.71) (check all that apply)

- ☐ Bottle seals were filled out while still affixed to the CCF

Step 4 Requirements (§40.73) (check all that apply)

- ☐ Missing collector's signature
- ☐ Missing collector's printed name (First, MI, Last)
- ☐ Missing/Incorrect Date of Collection
- ☐ Missing/Incorrect Time of Collection
- ☐ Missing Courier Name

Step 5 Requirements (§40.73) (check all that apply)

- ☐ Missing donor's signature
- ☐ Missing donor's printed name (First, MI, Last)
- ☐ Missing/Incorrect Date of Collection
- ☐ Missing donor's Daytime and/or Evening Phone No.
- ☐ Missing/Incorrect donor's Date of Birth

Collector Remarks:

1. Description of error: _____

2. Description of corrective action: _____

3. Measures taken to ensure the same error(s) do not reoccur: _____

By signing below, in accordance with 49 CFR Part 40.209, I certify that the aforementioned errors occurred on the referenced drug test and that appropriate measures have been taken to ensure the same errors will not reoccur.

Collector Signature / Title _____

Date _____

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. John Johnson ACME County Transit 123 Evergreen Street Springfield, OH 45482 P.937-252-0000 F.937-252-0001		B. MRO Name, Address, Phone No. and Fax No. Dr. Pamela Smith MRO Review Co. 555 Brown Ave Grennware, WY 96581	
C. Donor SSN, Employee I.D., or CDL State and No. <u>111-23-4567</u>		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 checked="" type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG	
E. Reason for Test: <input type="checkbox"/> Pre-employment <input checked="" 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 checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____	
G. Collection Site Address: ICUP Services 174 Spruce Blvd Springfield, OH 45482		Collector Contact Info: Phone <u>937-552-8954</u> Fax <u>937-552-8955</u> Other _____	

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

COLLECTION: <input checked="" 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 checked="" 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: <i>-- (If anything is written in "remarks" make sure you read it, understand it, and act if necessary)</i>

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 <u>FRANK ROSE</u> Signature of Collector <u>FRANK ROSE</u> (PRINT) Collector's Name (First, MI, Last)	<u>USPS</u> Name of Delivery Service
<u>04/13/23</u> <u>07:57</u> ^{AM} _{PM} 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.			
X <u>SEAN L. SMITH</u> Signature of Donor (PRINT) Donor's Name (First, MI, Last)	<u>04/13/23</u> Date (Mo/Day/Yr)		
Email address: _____	Daytime Phone No. <u>937 299/100</u>	Evening Phone No. <u>SAME</u>	Date of Birth <u>12/11/80</u> (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:	
<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE for: _____ <input type="checkbox"/> DILUTE	<input type="checkbox"/> TEST CANCELLED
<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: _____	
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"/> FAILED TO RECONFIRM for: _____	<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) _____

COPY 4 - EMPLOYER COPY

OMB No. 0930-0158

Alcohol Testing Form (ATF) Review Checklist

- Does the form read “*U.S. Department of Transportation (DOT) Alcohol Testing Form*” at the top?
- **In Step 1:**
 - ☐ Is the correct employee’s name and ID number or SSN listed?
 - ☐ Is the correct employer name and address listed?
 - ☐ Is the DER name and phone number accurate?
 - ☐ Is the reason for the test marked correctly?
- **In Step 2:**
 - ☐ Did the employee sign and date the form?
- **In Step 3:**
 - ☐ Did the alcohol technician designate his/her title (BAT or STT), and indicate the type of device used?
 - ☐ Is the testing facility information listed accurately?
 - ☐ Did the alcohol technician sign and date the ATF?
 - ☐ If a confirmation test was performed, was the 15-minute waiting period observed (i.e. is the “Yes” box checked)?
 - If a confirmation test was not performed, neither the “Yes” nor “No” box should be checked.
 - ☐ If a confirmation test result is 0.02 or greater, did the employee sign Step 4? If not, did the BAT make an appropriate comment in the remarks section?
- **EBT Printout:**
 - ☐ Are the printed results for a screening or confirmation test affixed to the ATF with tamper-evident tape, if not printed directly on the form?
 - The results of a screening test below 0.02 may be hand-printed on the ATF in Step 3 if the screening device is not designed to print.

DOT Alcohol Testing Form - Affidavit of Correction

According to 49 CFR Part 40, the alcohol technician of the alcohol test referenced below must take all practicable action to correct errors on the DOT Alcohol Testing Form.

Date of Test: _____

Alcohol Test #: _____

Donor Name: _____

Technician Name: _____

This affidavit addresses the following errors:

Use of DOT Alcohol Testing Form (§40.227):

_____ Incorrect form used (i.e. Non-DOT testing form used)

Step 1 Requirements (§40.241) Check all that apply:

- _____ A. Missing/Incorrect Employee Name
- _____ B. Missing/Incorrect Donor SSN or Employee ID No.
- _____ C. Missing/Incorrect Employer Name, Address
- _____ C. Missing/Incorrect DER Name, Phone No.
- _____ D. Missing/Incorrect Reason for Test

Step 2 Requirements (§40.241)

_____ Missing Date of Employee's Signature

Step 3 Requirements (§40.243-§40.251):

- _____ Missing Technician's title (BAT or STT)
- _____ Technician failed to indicate the type of device used
- _____ Technician failed to mark the 15-minute waiting period was observed (If confirmation test was performed)
- _____ Technician arbitrarily marked the 15-minute waiting period (no confirmation test was performed)
- _____ Missing Screening Test information (if device is not designed to print)
- _____ Missing appropriate comment in the Remarks (i.e. any unusual circumstances during the collection)
- _____ Missing/Incorrect Alcohol Technician's Company Name, Address
- _____ Missing/Incorrect Alcohol Technician's Printed Name (First, MI, Last)
- _____ Missing Alcohol Technician's Signature
- _____ Missing/Incorrect Date of Alcohol Technician's Signature

Technician Remarks (Description of error/corrective action): _____

In accordance with 49 CFR Part 40.271, I certify that the information above is true and accurate.

Alcohol Technician Signature

Date

U.S. Department of Transportation (DOT)

Alcohol Testing Form

(The instructions for completing this form are on the back of Copy 3)

STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name JOE DOE
(Print) (First, M.I., Last)

B: SSN or Employee ID No. 2164

C: Employer Name CITY TRANSIT
Street 21 MAIN ST.

City, State, ZIP SOMEWHERE, MA 02111
DER Name and Telephone No. CANDICE SMITH 617 215 3100
DER Name DER (Area Code & Phone Number)

D: Reason for Test: ☒ Random ☐ Reasonable Susp. ☐ Post-Accident ☐ Return to Duty ☐ Follow-up ☐ Pre-employment

STEP 2: TO BE COMPLETED BY EMPLOYEE

I certify that I am about to submit to alcohol testing required by U.S. Department of Transportation regulations and that the identifying information provided on the form is true and correct.

Signature of Employee [Signature] Date 11 / 28 / 18
Month / Day / Year

STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN

(If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual in accordance with the procedures established in the U.S. Department of Transportation regulations, 49 CFR Part 40, that I am qualified to operate the testing device(s) identified, and that the results are as recorded.

TECHNICIAN: ☒ BAT ☐ STT DEVICE: ☐ SALIVA ☒ BREATH* 15-Minute Wait: ☐ Yes ☐ No

SCREENING TEST: (For BREATH DEVICE* write in the space below only if the testing device is not designed to print.)

Test #	Testing Device Name	Device Serial # QR Lot # & Exp. Date	Activation Time	Reading Time	Result
CONFIRMATION TEST: Results <u>MUST</u> be affixed to each copy of this form or printed directly onto the form.					

REMARKS:

Collect-N-Go
Alcohol Technician's Company

Tammy Johnson
(PRINT) Alcohol Technician's Name (First, M.I., Last)

3 Park St.
Company Street Address

SOMEWHERE, MA 02111
Company City, State, Zip

617 215 3430
Phone Number (Area Code & Number)

[Signature]
Signature of Alcohol Technician

11/28/2018
Date Month / Day / Year

STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS 0.02 OR HIGHER

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are 0.02 or greater.

Signature of Employee Date Month / Day / Year

EVIDENT

RBT IUM 012854
DATE 11-28-18
TEST NO. 0345
ID#

2164
AS IUM 005066
SCREENING
G/210L TIME

000 AUTO 10/14

TAMPER