



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for Office of Management and Budget (OMB) Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Government Paperwork Elimination Act (GPEA) 44 U.S.C. 3504. To request a copy of these documents, call the SAMHSA Reports Clearance Officer at (240) 276-1243.

**Project: Mandatory Guidelines for Federal Workplace Drug Testing Programs (OMB No. 0930-0158)-Revision**

SAMHSA will request OMB approval for the Federal Drug Testing Custody and Control Form (Federal CCF) for federal agency and federally regulated drug testing programs which must comply with the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs (73 FR 71858) dated November 25, 2008, and OMB approval for the information provided by test facilities (i.e., laboratories and Instrumented Initial Test Facilities, IITFs) for the National Laboratory Certification Program (NLCP).

The Federal CCF is used by all federal agencies and employers regulated by the Department of Transportation (DOT) to document the collection and chain of custody of drug testing specimens at the collection site, for the test facility to report results, and for the Medical Review Officer (MRO) to make a determination. The current OMB-approved Federal CCF has an August 31, 2013 expiration date. In accordance with the GPEA, OMB set terms of clearance for the extension of the current Federal CCF as follows: Prior to the next approval of this package, the Agency (SAMHSA) shall provide a progress update on adoption of electronic forms in an effort to reduce burden. SAMHSA is encouraged to explore ways to convert the Federal Drug Testing

Custody and Control Form (Federal CCF) into an electronic form.

In an effort to comply with the stated terms of the clearance requirement set forth by OMB, SAMHSA will authorize the use of an electronic Federal CCF. SAMHSA has resubmitted the Federal CCF with no content revisions to the form for OMB approval. The only revisions are to enable the form to be used as a paper form or as an electronic form.

- The first change to the Federal CCF is to allow the Public Burden Statement to be a separate page of an electronic Federal CCF. The Public Burden Statement must appear on all federal government forms that place a reporting burden on gathering information.
- The second change is to allow the Federal CCF instructions and the Privacy Act Statement to be on a separate page or pages of an electronic Federal CCF.
- The third change is to allow the bottle labels/seals to be printed separately, and not as a part of Copy 1 of the Federal CCF.
- The fourth change is to revise the Federal CCF Instructions to allow the use of an electronic form.

Below is a copy of the Federal CCF:

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 0000001

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE** ACCESSION NO. \_\_\_\_\_

A. Employer Name, Address, I.D. No. \_\_\_\_\_ B. MRO Name, Address, Phone No. and Fax No. \_\_\_\_\_

C. Donor SSN or Employee I.D. No. \_\_\_\_\_

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: \_\_\_\_\_

Collector Phone No. \_\_\_\_\_  
Collector Fax No. \_\_\_\_\_

**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 \_\_\_\_\_

**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: \_\_\_\_\_

Signature of Collector \_\_\_\_\_ AM \_\_\_\_\_  
Date (Mo/Day/Yr) \_\_\_\_\_ Time of Collection \_\_\_\_\_ PM \_\_\_\_\_  
(PRINT) Collector's Name (First, MI, Last) \_\_\_\_\_ Name of Delivery Service \_\_\_\_\_

**RECEIVED AT IITF:**  \_\_\_\_\_ SPECIMEN BOTTLE(S) RELEASED TO: \_\_\_\_\_

Signature of Accessioner \_\_\_\_\_ IITF Name and Address (if not above): \_\_\_\_\_  
Date (Mo/Day/Yr) \_\_\_\_\_ Primary Specimen Bottle Seal Intact  YES  NO  
(PRINT) Accessioner's Name (First, MI, Last) \_\_\_\_\_ If NO, Enter remark In Step 5A.

**TRANSFER FROM IITF TO LAB.** I certify that the specimen identified on this form was handled using chain of custody procedures and resealed in accordance with applicable Federal requirements.

\_\_\_\_\_ SPECIMEN BOTTLE(S) RELEASED TO: \_\_\_\_\_

Signature \_\_\_\_\_ (PRINT) Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_ Name of Delivery Service \_\_\_\_\_

**RECEIVED AT LAB:**  \_\_\_\_\_ SPECIMEN BOTTLE(S) RELEASED TO: \_\_\_\_\_

Signature of Accessioner \_\_\_\_\_ Primary Specimen Bottle Seal Intact  YES  NO  
Date (Mo/Day/Yr) \_\_\_\_\_ If NO, Enter remark In Step 5A.

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

**STEP 5B: COMPLETED BY SPLIT TESTING LABORATORY**

**SPLIT SPECIMEN TESTED; SEE LABORATORY REPORT** \_\_\_\_\_  
 Split Testing Laboratory (Name, City, State)

 0000001 SPECIMEN ID NO.	A	PLACE OVER CAP	0000001 SPECIMEN BOTTLE SEAL	_____ Date (Mo/Day/Yr) _____ Donor's Initials
 0000001 SPECIMEN ID NO.	B (SPLIT)	PLACE OVER CAP	0000001 SPECIMEN BOTTLE SEAL	_____ Date (Mo/Day/Yr) _____ Donor's Initials

COPY 1 - TEST FACILITY COPY

OMB No. 0930-0158

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

**Paper CCF: Back of Copy 1-4**  
**Electronic CCF: Separate Page**

**Public Burden Statement**

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, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

A. Employer Name, Address, I.D. No. _____  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. _____	B. MRO Name, Address, Phone No. and Fax No. _____          Collector Phone No. _____ Collector Fax No. _____
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OMB No. 0930-0158

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

Temperature between 90° and 100° F? <input checked="" 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.  X _____ Signature of Collector _____ AM _____ PM _____ (PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____ Time of Collection _____	SPECIMEN BOTTLE(S) RELEASED TO:   Name of Delivery Service _____
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**STEP 5: COMPLETED BY DONOR**

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.

X \_\_\_\_\_  
 Signature of Donor \_\_\_\_\_ (PRINT) Donor's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 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**

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 (# 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

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

A. Employer Name, Address, I.D. No. _____  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: _____	B. MRO Name, Address, Phone No. and Fax No. _____     Collector Phone No. _____ Collector Fax No. _____
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**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 \_\_\_\_\_

**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.*

X _____ Signature of Collector _____ AM _____ PM (PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____ Time of Collection _____	SPECIMEN BOTTLE(S) RELEASED TO:   _____ Name of Delivery Service
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**STEP 5: COMPLETED BY DONOR**

*I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.*

X \_\_\_\_\_  
 Signature of Donor \_\_\_\_\_ (PRINT) Donor's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 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**

*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

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

A. Employer Name, Address, I.D. No. _____  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. _____	B. MRO Name, Address, Phone No. and Fax No. _____          
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**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.  X _____ Signature of Collector _____ AM _____ PM (PRINT) Collector's Name (First, MI, Last) / Date (Mo/Day/Yr) Time of Collection	SPECIMEN BOTTLE(S) RELEASED TO:    _____ Name of Delivery Service
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**STEP 5: COMPLETED BY DONOR**

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.

X \_\_\_\_\_ (PRINT) Donor's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 Signature of Donor  
 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**

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 \_\_\_\_\_ (PRINT) Medical Review Officer's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 Signature of Medical Review Officer

**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 \_\_\_\_\_ (PRINT) Medical Review Officer's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 Signature of Medical Review Officer

COPY 4 - EMPLOYER COPY

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. **0000001**

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

ACCESSION NO.

A. Employer Name, Address, I.D. No. _____  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, PCR, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (specify) _____ G. Collection Site Address: _____  Collector Phone No. _____ Collector Fax No. _____	B. MRO Name, Address, Phone No. and Fax No. _____          Collector Phone No. _____ Collector Fax No. _____
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**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.  X _____ Signature of Collector _____ AM _____ PM (PRINT) Collector's Name (First, MI, Last) _____ Date (Mo/Day/Yr) _____ Time of Collection _____	SPECIMEN BOTTLE(S) RELEASED TO:    Name of Delivery Service _____
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**STEP 5: COMPLETED BY DONOR**

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle 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 is correct.

X \_\_\_\_\_  
 Signature of Donor \_\_\_\_\_ (PRINT) Donor's Name (First, MI, Last) \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_  
 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**

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

**Paper CCF: Back of Copy 5**  
**Electronic CCF: Separate Page**

**Instructions for Completing the Federal Drug Testing Custody and Control Form for Urine Specimen Collection**

*When making entries on a paper CCF, use black or blue ink pen and press firmly*

Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory are on the top of the Federal CCF and the Specimen Identification (I.D.) number on the top of the Federal CCF matches the Specimen I.D. number on the labels/seals.

**STEP 1:**

- Collector ensures that the required information is in STEP 1. Collector enters a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee I.D. number.
- Collector gives collection container to Donor and instructs Donor to provide a specimen. Collector notes any unusual behavior or appearance of Donor in the remarks line in STEP 2. If the Donor's conduct at any time during the collection process clearly indicates an attempt to tamper with the specimen, Collector notes the conduct in the remarks line in STEP 2 and takes action as required.

**STEP 2:**

- Collector checks specimen temperature within 4 minutes after receiving the specimen from Donor, and marks the appropriate temperature box in STEP 2. If the temperature is outside the acceptable range, Collector enters a remark in STEP 2 and takes action as required.
- Collector inspects the specimen and notes any unusual findings in the remarks line in STEP 2 and takes action as required. Any specimen with unusual physical characteristics (e.g., unusual color, presence of foreign objects or material, unusual odor) cannot be sent to an IITF and must be sent to an HHS-certified laboratory for testing, as required.
- Collector determines the volume of specimen in the collection container. If the volume is acceptable, Collector proceeds with the collection. If the volume is less than required by the federal agency, Collector takes action as required, and enters remarks in STEP 2. If no specimen is collected by the end of the collection process, Collector checks the *None Provided* box, enters a remark in STEP 2, discards Copy 1, and distributes remaining copies as required.
- Collector checks the Split or Single specimen collection box. If the collection is observed, Collector checks the Observed box and enters a remark in STEP 2.

**STEP 3:**

- Donor watches Collector pour the specimen from the collection container into the specimen bottle(s), place the cap(s) on the specimen bottle(s), and affix the label(s)/seal(s) on the specimen bottle(s).
- Collector dates the specimen bottle label(s) after placement on the specimen bottle(s).
- Donor initials the specimen bottle label(s) after placement on the specimen bottle(s).
- Collector instructs the Donor to read and complete the certification statement in STEP 5 on Copy 2 (signature, printed name, date, phone numbers, and date of birth). If Donor refuses to sign the certification statement, Collector enters a remark in STEP 2 on Copy 1.

**STEP 4:**

- Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service) and places the sealed specimen bottle(s) in a leak-proof plastic bag.
- Paper CCF: Collector places Copy 1 in the leak-proof plastic bag. Electronic CCF: Collector places printed copy of Copy 1 in the leak-proof plastic bag and/or places package label (with Specimen I.D., test facility name and contact information, and collection site name and contact information) on the outside of the bag.
- Collector seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required.

**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 for the presence of illegal drugs. 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**

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, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

The number of respondents has been reduced from 7.1 to a total of 6.1 million; which reduces the total burden hours of -240,480.

Prior to an inspection, each test facility is required to submit specific information regarding its procedures. Collecting this information prior to an inspection allows the inspectors to thoroughly review and understand the testing procedures before arriving at the test facility.

The NLCP application form has not been revised compared to the previous form.

The annual total burden estimates for the Federal Drug Testing Custody and Control Form, the NLCP application, the NLCP inspection checklist, and NLCP recordkeeping requirements are shown in the following table.

Number of Form/Respondents	Burden/Responses (hours)	Responses/respondent	Total Burden Hours
Custody and Control Form			
Donor	.08	6,150,000	512,500
Collector	.07	6,150,000	410,000
Laboratory	.05	6,150,000	307,500
Medical Review Officer	.05	6,150,000	307,500
Laboratory Application	3.0	3	9
Laboratory Inspection Checklist	2.0	35	70
Laboratory Recordkeeping	250.0	35	8750
<b>Total</b>			<b>1,546,329</b>

Written comments and recommendations concerning the proposed information collection should be sent by [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER] to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB’s receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via e-mail to:

[OIRA\\_Submission@omb.eop.gov](mailto:OIRA_Submission@omb.eop.gov). Although commenters are encouraged to send their

comments via e-mail, commenters may also fax their comments to: 202-395-7285. Commenters

may also mail them to: Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 10102, Washington, D.C. 20503.

Summer King  
Statistician

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