Central Occupational Medicine Providers

Comprehensive Industrial Case Management & Treatment Centers

DOT INTAKE FORM

(*DOT FORMA DE ADMISIÓN)*

Patient No 18-_____

Sign In Date _____

First Name *(Nombre)*: _____ Middle Initial *(Inicial de 2do Nombre)*: _____ Last Name *(Apellido)*: _____

Social Security Number *(Numero de Seguro Social)*: _____ - _____ - _____

Sex *(Sexo)*: ☐ Male *(Masculino)* ☐ Female *(Femenino)* Date of Birth *(Fecha de Nacimiento)*: _____ / _____ / _____

Address *(Domicilio)*: _____

City *(Ciudad)*: _____ State *(Estado)*: _____ Zip Code *(Código Postal)*: _____

Telephone# *(Teléfono)*: Home *(Casa)*: ( ) _____ - _____ Cell *(Celular)*: ( ) _____ - _____

Email *(Correo Electrónico)*: _____

Employer/Agency *(Compañía/ Agencia)*: _____ Occupation *(Ocupación)*: _____

Medications(s) Taken, Include Supplements *(Medicamento(s) Tomados (Incluyendo Suplementos)* _____

_____

_____

_____

Signature *(Firma)*

_____

Date *(Fecha)*

REFUSAL *(RECHAZO)*

I, the undersigned, hereby refuse to authorize the testing of my samples for screening purposes and / or the release of my medical results to my employer / agency. Furthermore, by doing this I fully understand that my refusal may be considered to be the same as a positive test depending on the policy my company follows.

Yo, el abajo firmante, me niego a autorizar las pruebas de mis muestras con fines de detección y/o la emisión de los resultados de mi médico a mi empleador/agencia. Además, al hacer esto, entiendo perfectamente que mi rechazo puede ser considerado como un examen positivo dependiendo de la póliza laboral de la compañía para la cual trabajo.

_____

Signature *(Firma)*

_____

Date *(Fecha)*

BACK COPY 5

Instructions for Completing the Federal Drug Testing Custody and Control Form

When making entries 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 CCF and that the Specimen I.D. number on the top of the 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 Donor 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 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)/seal(s) after placement on the specimen bottle(s).
- Donor initials the specimen bottle label(s)/seal(s) after placement on the specimen bottle(s).
- Collector turns to Copy 2 (Medical Review Officer Copy) and instructs Donor to read and complete the certification statement in STEP 5 (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), places the sealed specimen bottle(s) and Copy 1 of the CCF in a leak-proof plastic bag, 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 attached form is voluntary. However, incomplete submission of the information, refusal to provide a urine 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 urine specimen and identifying information contained herein is Executive Order 12564 ("Drug-Free Federal Workplace"), 5 U.S.C. Sec. 3301 (2), 5 U.S.C. Sec. 7301, and Section 503 of Public Law 100-71, 5 U.S.C. Sec. 7301 note. Under provisions of Executive Order 12564 and 5 U.S.C. 7301, test results may only be disclosed to agency officials on a need-to-know basis. This may include the agency Medical Review Officer (MRO), the administrator of the Employee Assistance Program, and a supervisor with authority to take adverse personnel action. This information may also be disclosed to a court where necessary to defend against a challenge to an adverse personnel action.

Submission of your SSN is not required by law and is voluntary. Your refusal to furnish your number will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited, pursuant to Executive Order 9397, for purposes of associating information in agency files relating to you and for purposes of identifying the specimen provided for testing. If you refuse to indicate your SSN, a substitute number or other identifier will be assigned, as required, to process the specimen.

Public Burden Statement:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0158. Public reporting burden for this collection of information is estimated to average: 5 minutes/donor; 4 minutes/collector; 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

I here by acknowledge I have read and understood the above steps that will be performed for my drug test.

_____ _____

Name and Signature Date

Patient No 19-_____

↓↓↓ For Clinic Use Only *(Uso Único De Clinica)* ↓↓↓

ADDITIONAL NOTES OR COMMENTS:

DATE / TIME / INITIAL	REASON

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GENERAL AUTHORIZATION AND CONSENT FORM

(AUTORIZACIÓN Y CONSENTIMIENTO GENERAL)

Patient No 19-_____

Sign in Date_____

☐ MA Initial _____

☐ Quick Test (5 / 9 / 10 / 12 / E-Cup)

☐ *Negative* ☐ *Further Testing Needed*

FTN for what type of drug? _____

☐ *Temperature between 90 – 100 Degrees* _____ *°F*

☐ DSS (Nida / Non-Nida / Single / Split / Hair / Other)

☐ COL (Nida / Non-Nida / Single / Split / Hair / Other)

☐ BAT (Nida / Non-Nida)

☐ Audio

☐ Physical Agility Test (PAT)

☐ Pulmonary Function Test

☐ Mask Fit

☐ N95

☐ _____

Age _____

☐ Reports

☐ Dot Physical

☐ Return to Work

☐ Biometric Physical

☐ Intermediate Physical

☐ PPD / TB

☐ Hep B

☐ Titer

☐ MMR

☐ HEP-B

☐ Varicella

☐ Bio _____ lbs

☐ Lift Test _____ lbs

☐ Back X-Ray ☐ Chest X-Ray

☐ EDEX

☐ Jamar

☐ Flu

☐ Tetanus/TDAP

Date of Last Tetanus Shot

_____

Donor/Patient Signature: _____

Date: _____

Taken Out By: _____