

## **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
- ☐ 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 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

## **'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 \_\_\_\_\_. \_\_\_\_\_ sent an  
*Date* *Agency Name*

'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*

\_\_\_\_\_ 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)

# 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; providing false information in connection with said 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: \_\_\_\_\_

You must report no later than \_\_\_\_\_ am/pm, 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 Time Notified

Designated Employer Representative / DAPM: \_\_\_\_\_  
Print Name Phone Number

# 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: \_\_\_\_\_ ID # and 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 FTA Authority ☐ Yes 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: \_\_\_\_\_

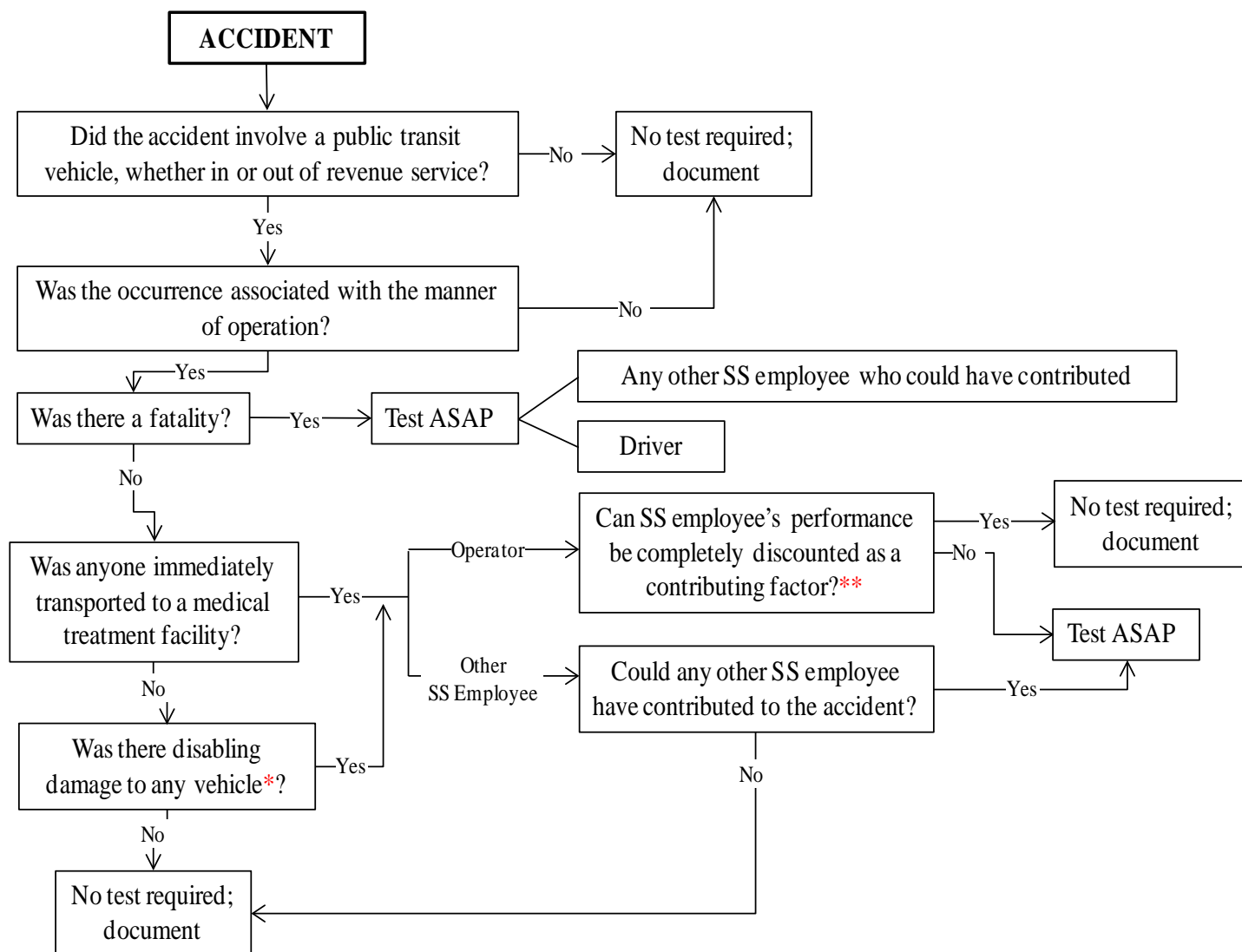
Signature & Title \_\_\_\_\_

Date \_\_\_\_\_

For your files: attach test results summary, order to test, Custody and Control Form (USDOT) and alcohol testing form (USDOT)

\* Attach supporting documentation covering any descriptions/documentation of disabling damage, medical treatment away from the scene, and/or fatalities. (e.g., accident investigation form, etc.)

## 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.

**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 compliance with all 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*

# POSITIVE DRUG AND ALCOHOL TESTING LOG

Employee	Date/Time of Positive Result	Type of Violation	SAP Referral	Outcome	Transferred all documentation to this folder?	
					Yes No 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
		<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 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 urine 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 urine drug test has a verified negative result.

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Signature of Applicant

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Date

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Print Name

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Date

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

# PRE-EMPLOYMENT TESTING LOG

[illegible]

# 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:
	<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:
	<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:
	<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:
	<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:
	<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:

# 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:	Initial
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	<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"/> 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"/> 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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Initial

# CONFIDENTIAL

## 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.**

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## **REASONABLE SUSPICION INCIDENT CHECKLIST**

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Employee's Full Name

---

Date / Time of Observation

---

Supervisor's Full Name & Telephone

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Date of Supervisor's Reasonable Suspicion Decision Training

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This checklist is to be completed when a supervisor – trained in accordance with 49 CFR Part 655.14(b) – 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.

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**A. Nature of Incident / Cause for Suspicion**

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- ☐ 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 (e.g. flagrant violation of safety or serious misconduct, accident or 'near miss,' fighting or argumentative/abusive language, refusal of supervisor instruction, unauthorized absence on the job) Please specify:

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**B. Behavioral Indicators**

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- ☐ 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

*Forward this document to the drug and alcohol program manager*

# 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
<b>Return to Duty Test</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		N/A	N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Follow-up Test*</b>		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.



**CONFIDENTIAL**

**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 \_\_\_\_\_.

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

*If the employee refuses to sign this form, please document why*

**CONFIDENTIAL**  
**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

## **SAFETY-SENSITIVE FUNCTIONS DETERMINATION WORKSHEET**

<b>1</b>	Do you receive <u><b>any</b></u> funding as a recipient, subrecipient, or contractor under: A) 49 U.S.C. 5307, 5309, or 5311; or B) 24 U.S.C. 103(e)(4)	Yes ____ No ____  If yes, continue to #2
<b>2</b>	Regardless of job title or department, do you directly employ any personnel that perform any of the following functions for the transit system:	
	A) Operate a transit vehicle?	Yes ____ No ____
	B) Operate a transit vehicle, when required to be operated by a holder of a CDL?	Yes ____ No ____
	C) Control dispatch or movement of a transit vehicle?	Yes ____ No ____
	D) Provide maintenance for transit vehicles? - Preventative maintenance - Repairs - Overhaul - Rebuilding	Yes ____ No ____
	E) Carry a firearm for security purposes?	Yes ____ No ____
<b>3</b>	Do you contract out any services for the transit system?	Yes ____ No ____  If yes, continue to #4  If no, skip to #5
<b>4</b>	Regardless of job title or department, do you directly employ any personnel, outside of the contracted services, that could be expected to perform any of the functions listed in #2 above for the transit system?	Yes ____ No ____
<b>5</b>	<b>If you answered YES to any question in #2 or #4:</b> - You employ personnel that are considered safety sensitive and are subject to testing under 49 CFR Parts 655 and 40; and - You are required to establish an anti-drug use and alcohol misuse program consistent with 49 CFR Parts 655 and 40.	
<b>N O T E S</b>	- Volunteers are considered safety-sensitive, and subject to testing, only if they are required to hold a CDL, or receive remuneration for service in excess of actual expenses.  - Supervisors are safety-sensitive if they may perform one of the above functions.  - The maintenance section does not apply to the following: A) An employer: - Receiving funds under 49 U.S.C. 5307 or 5309 <b>AND</b> - In an area less than 200,000 in population <b>AND</b> - <u>Contracts</u> out such maintenance services B) An employer: - Receiving funds under 49 U.S.C. 5311 <b>AND</b> - <u>Contracts</u> out such maintenance services	

## 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			

# **COLLECTION SITE 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 on the National Highway Traffic Safety Administration (NHTSA) conforming products list?
- ☐ 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.dot.gov/ost/dapc](http://www.dot.gov/ost/dapc))

- ☐ 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)

## **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 (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 DOT and 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 tank 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 = between 90 and 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.