

## CHAIN OF CUSTODY FORM INSTRUCTIONS

Current Version of Form: 03/2016

**CHAIN OF CUSTODY FORM**  
Customer Service: 800-444-7997

OTS - SOUTHAVEN  
LABCORP  
1120 MAIN STREET  
SOUTHAVEN, MS 38671  
3000

0973388894

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

<p><b>A. Employer Name, Address and I.D. No.</b>                      RN EXPERTISE                      691 DOUGLAS AVE/STE 101                      ALTAMONTE SPRINGS FL 32714                      407-865-6544                      FAX: 407-865-7993</p>	<p><b>B. MRO Name, Address, Phone and Fax No.</b>                      RN EXPERTISE                      ATTN: DAVID PARSONS, M.D.                      691 DOUGLAS AVE/STE 101                      ALTAMONTE SPRINGS FL 32714                      407-865-6544                      FAX: 407-865-7993</p>
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**C. Donor SSN or Employee I.D. No.** \_\_\_\_\_

**D. Reason for Test:**  Pre-Employment  Random  Reasonable Suspicion/Cause  Post Accident  Periodic  Other \_\_\_\_\_

**E. Collection Site Address:** \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Collector Phone No. \_\_\_\_\_  
Collector Fax No. \_\_\_\_\_

**F. Donor Identification Verified By:**  Photo I.D.  Employer Representative

**STEP 2 TO BE COMPLETED BY COLLECTOR**

Read specimen temperature within 4 minutes. Is temperature between 90° and 100°F? Yes  No, Enter Reason Below  Split Specimen Collection Yes  No

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

**STEP 3 TO BE COMPLETED BY COLLECTOR AND DONOR - Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).**

**STEP 4 TO BE COMPLETED BY COLLECTOR AND DONOR**

**G. Daytime Phone No. ( ) - ( ) - ( )**      **Evening Phone No. ( ) - ( ) - ( )**      **Date of Birth: / /**

**H. TEST(S) REQUESTED BY EMPLOYER:**  
 - PROFILE 1 - 5 PANEL  
 - PROFILE 2 - 9 PANEL  
 - PROFILE 3 - BLOOD ALCOHOL ONLY

I authorize the collection of this specimen for the purpose of a drug screen. I acknowledge that the specimen container(s) was/were sealed with tamper-proof seal(s) in my presence, and that the information provided on this form and on the label(s) affixed to the specimen container(s) is correct. I authorize the laboratory to release the results of the test to the company identified on this form or its designated agent.

(PRINT) DONOR'S NAME (FIRST, MI, LAST) \_\_\_\_\_ SIGNATURE OF DONOR \_\_\_\_\_ INITIAL \_\_\_\_\_ MONTH / DAY / YEAR \_\_\_\_\_

**STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY**

I certify that the specimen given to me by the donor identified on this form was collected, sealed, packed and released to the Delivery Service listed below in accordance with applicable requirements.

<p>Signature of Collector _____ Title of Collector _____ Print Collector's Name (First, MI, Last) _____</p>	<p>AM _____ PM _____ Date of Collection _____ (MM, DD, YYYY)</p>	<p><b>SPECIMEN BOTTLE(S) RELEASED TO:</b> _____ Name of Delivery Service (including Street, S.L.#) _____</p>
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**RECEIVED AT LAB:**

<p>Signature of Accession _____ Printed Accession (Last, First, MI, Last) _____</p>	<p>Primary Specimen Bottle Seal Intact <input type="checkbox"/> Yes <input type="checkbox"/> No, Enter Remark Below</p>	<p><b>SPECIMEN BOTTLE(S) RELEASED TO:</b> _____ DATE _____ DONOR'S INITIALS _____ DATE _____ DONOR'S INITIALS _____</p>
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Printed: 06/10

**CONTAINER SEAL**

OTS - SOUTHAVEN 3000  
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COPY 1 - LABORATORY

SI 44740

### PURPOSE:

- Used to have all employees involved in accidents tested
- To be in compliance with the Post Accident Drug Test Policy

### PREPARATION:

- Provide the injured worker a blue Chain of Custody form to take to the testing vendor
- Check the block marked 'OTHER'
- Write Workers' Comp in the blank next to 'other'

**DISPOSITION:**

- The cost of the post-accident drug testing will be paid on the workers' compensation claim
- By checking the 'other' box and writing workers' compensation in the blank, RN Expertise will know to bill Sedgwick directly for the testing