



Authorization for Examination or Treatment

Authorization ID: 201757

This authorization expires on 04/23/2022.

Patient must present photo ID at time of service. If ID other than government issue is used list here:

Employee Information

Personal Info

Name:
Watkins, Ronald

Date Of Birth:
09/17/1980

Location Information

Employer:
Roy Salmon Trucking

Location Name:
Roy Salmon Trucking

Contact Name:
Roy Salmon

Location Phone:
(443)-629-4648

Street Address:
9737 Eustice Rd

City, State, ZIP:
Randallstown, MD, 21133-2511

Processing Info

Staffing Agency / PEO:

Alternate ID:

PO#:

Service Information

Services and Components

Service Package Selected:
Reg UDS & BAT PrePl

Required Components:

- Breath Alcohol Test
PrePlacement
- Regulated UDS
PrePlacement 65304

Special Instructions/Comments:

Authorization

Authorized by:
Roy Salmon

Title:
Primary Contact

Phone:
(443) 629-4648

Issuance Date:
04/22/2022

Authorization Expires:
04/23/2022

Suggested Concentra Center

Timonium

Phone: 410-252-4015

Fax: 410-252-7410

1830 York Road

Ste. F

Timonium, MD 21093

Due to the nature of these specific services, only the patient and staff are allowed in the testing/ treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7919660664



800-877-7484

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. Roy Salmon Trucking - 2818-22749 9737 Eustice Rd Randallstown, MD 21133 Phone: 443-629-4648 Fax: 443-295-3806		Lab Acct #: 65025818	B. MRO Name, Address, Phone and Fax No. Michelle Alexander, M.D. 8140 Ward Parkway Kansas City, MO 64114 Phone: 888-382-2281 Fax: 913-469-4029
C. Donor SSN, Employee I.D., or GDL State and No. MDW325744402721			
D. Specify Testing Authority: <input type="checkbox"/> HHS <input type="checkbox"/> NRC Specify DOT Agency: <input checked="" 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 checked="" 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 checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (Specify)			
G. Collection Site Address: Concentra Timonium - 2812 1830 YORK RD STE F TIMONIUM, MD 21093		Collector Contact Info: Phone 410-252-4015 Fax 410-252-7410 Other	

2812-BB863

Clinic ID

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	<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID
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:	

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

X	Signature of Collector Sarina Dumas (PRINT) Collector's Name (First, MI, Last)	04 / 22 / 2022 Date (Mo./Day/Yr.)	11:02:30 Time of Collection	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO: QUEST Name of Delivery Service
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STEP 5: COMPLETED BY DONOR

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 Ronald Watkins (PRINT) Donor's Name (First, MI, Last)	04 / 22 / 2022 Date (Mo./Day/Yr.)	09 / 17 / 1980 Date (Mo./Day/Yr.)
Email _____ Day Phone (443) 683-4755 Evening Phone () Not Provided		Date of Birth	

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 checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID
<input type="checkbox"/> Negative <input type="checkbox"/> Positive for : <input type="checkbox"/> Dilute <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:		<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.)

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.)

Claim Number:

Concentra Medical Centers (MD)

1830 York Rd Ste F TIMONIUM, MD 21093
Phone: (410) 252-4015 Fax: (410) 252-7410

Service Date: 04/22/2022

Non-Injury Work Status Report

Patient: Watkins, Ronald J.

SSN: XXXXX3857

Address: 343 High Knob Lane
REISTERSTOWN, MD 21136

Home: (443) 683-4755

Work: Ext.:

Employer Location: Roy Salmon Trucking

Address: 9737 Eustice Rd
Randallstown, MD 211325

Auth. by:

Contact: Roy Salmon

Role: Primary Contact

Phone: (443) 629-4648 **Ext.:**

Fax: (443) 299-6806

This Visit:

Time In: 10:19 am

Time Out: 10:50 am

Visit Type: New

Reg UDS & BAT PrePI

Breath Alcohol Test PrePlacement

Regulated UDS PrePlacement 65304

Result Status:

Job description was provided by employer and reviewed by examining provider
May work without limitations/restrictions

Remarks:

U.S. Department of Transportation (DOT)

Alcohol Testing Form

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

Print Screening Results
Here or Affix with
Tamper Evident Tape

Intoximeters RSU XL

Test Number: 4126
Serial Number: 18749
Test Date: 04/22/2022
Test Time: 10:49:16
Test Temperature: 24.0°C

Test Type: Screening
Reason for Test:
Pre-Employment

Type	g/210L	Time
BLNK	0.000	10:49:45
SUBJ	0.000	10:50:16

Test Status: Success

Print Confirmation
Results Here or Affix
with Tamper Evident
Tape

Print Additional
Results Here or Affix
With Tamper Evident
Tape

Step 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name

Ronald J Watkins

B: SSN or Employee ID No.

213 017 38 57

C: Employer Name

Boy Salmon Trucking

Street
City, State, Zip

9737 Eustice Rd

Bandallstown, MD 21133

DER Name and
Telephone No.

Boy Salmon

443-629-4648

DER Name

DER 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 US Department of Transportation regulations and that the identifying information provided on the form is true and correct.

Signature of Employee

Date Month Day Year

4 22 22

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 US Department of Transportation regulation, 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 # OR Lot # & Exp Date	Activation Time	Reading Time	Result
CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form.					

REMARKS:

Concentra Medical Center
1830 York Rd Ste F
Timonium MD 21093
P: 410-252-4015
F: 410-252-7410

Concentra
Alcohol Technician's Company
Sarina Dumas
(PRINT) Alcohol Technician's Name (First, M.I., Last)

Company Street Address

Company City, State, Zip

Phone Number

Signature of Alcohol Technician

Date Month Day Year

4 22 22

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

Form DOT F 1380 (Rev. 5/2008)

OMB No. 2105-0529

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER