

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

Step 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name Shawn Ho Sang
(Print) (First, M.I., Last)
B: SSN or Employee ID No. 105-32-5079
C: Employer Name Roy Salmon Trucking
Street 9727 Eustice Rd
City, State, Zip Randallstown, MD 21133
DER Name and Telephone No. Roy Salmon 443-629-4648
DER Name Roy Salmon DER Phone Number 443-629-4648
D: Reason for Test: ☐ Random ☐ Reasonable Susp ☐ Post-Accident ☐ Return to Duty ☐ Follow-up ☒ Pre-employment

Intoximeters ASV XL
Test Number: 6004
Serial Number: 16708
Test Date: 07/19/2022
Test Time: 14:13:28
Test Temperature: 25.5°C
Test Type: Screening
Reason for Test:
Pre-Employment

Type 9/210L Time
BLNK 0.000 14:13:40
SUBJ 0.000 14:14:05

Test Status: Success

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

7/19/22
Date Month Day Year

Print Confirmation
Results Here or Affix
with Tamper Evident
Tape

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
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CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form.

REMARKS:

Print Additional
Results Here or Affix
With Tamper Evident
Tape

Alcohol Technician's Company

Company Street Address

(PRINT) Alcohol Technician's Name (First, M.I., Last)

Company City, State, Zip

Phone Number

Signature of Alcohol Technician

7/19/22 4102479595
Date Month Day Year

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

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7923145286



STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.

Lab Acct #: 65017175

Roy Salmon Trucking - 2818-22749
9737 Eustice Rd
Randallstown, MD 21133
Phone: 443-629-4648 Fax: 443-299-6806

C. Donor SSN, Employee I.D., or CDL State and No. 705-32-5079

D. Specify Testing Authority: ☐ HHS ☐ NRCSpecify DOT Agency: ☒ FMCSA ☐ FAAE. 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:

Concentra Medical Center - Arbutus - 2826
1419 KNECHT AVE
BALTIMORE, MD 21227

2826-MD048

Clinic ID

Collector Contact Info: Phone 410-247-9595

Fax 410-247-7553

Other

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

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

Collection: ☒ Split ☐ Single ☐ None Provided, Enter Remark☒ URINE☐ ORAL FLUIDURINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? ☒ Yes ☐ No. Enter RemarkORAL FLUID: Split type: ☐ Serial ☐ Concurrent ☐ Subdivided Each Device Within Expiration Date? ☐ Yes ☐ No ☐ Observed, Enter RemarkREMARKS: ☐ Volume Indicator(s) Observed

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 dated in accordance with applicable Federal requirements.

X

Kristi Singh

Signature of Collector

07 / 19 / 2022

2:13:29

Time of Collection

☐ AM ☒ PM

(PRINT) Collector's Name (First, MI, Last)

Date (Mo./Day/Yr.)

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

FEDEX

Name of Delivery Service

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

Shaun Ho Sang

(PRINT) Donor's Name (First, MI, Last)

07 / 19 / 2022

Date (Mo./Day/Yr.)

Email _____ Day Phone (929) 600-1892 Evening Phone () Not Provided Date of Birth 01 / 23 / 1993

Date (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:

☒ URINE☐ ORAL FLUID☐ Negative☐ Positive for:☐ Dilute☐ Refusal to Test because - check reason(s) below:☐ ADULTERATED (adulterant/reason):☐ TEST CANCELLED☐ 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:☐ FAILED TO RECONFIRM for:☐ TEST CANCELLED

REMARKS:

X

Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)