

## ***REASONABLE SUSPICION TESTING CHECKLIST***

<b>Employee Name:</b> _____	<b>Employee Job Title:</b> _____
<b>Facility:</b> _____	<b>Location of Event:</b> _____
<b>Observation Date:</b> _____ <b>Time:</b> _____ a.m. / p.m.	
<b>Was employee performing a safety-sensitive duty?</b> Yes ____ No ____	

The following observations were made of the employee identified above:

Check **ALL** specific and contemporaneous observations and document the following:

**BEHAVIOR**

- Unsteady gait, stumbling
- Drowsy, sleepy, lethargic
- Agitated, anxious, restless
- Hostile, belligerent
- Irritable, moody
- Depressed, withdrawn
- Unfocused, blank stare
- Unresponsive, distracted
- Clumsy, uncoordinated
- Tremors, shakes
- Flu-like illness complaints
- Suspicious, paranoid
- Hyperactive, fidgety
- Inappropriate, uninhibited behavior
- Frequent use of mints, mouthwash, breath sprays, eye drops

**APPEARANCE**

- flushed complexion
- cold, clammy sweats
- bloodshot eyes
- tearing, watery eyes
- dilated (large) pupils
- constricted (pinpoint) pupils
- nonsensical, silly
- cursing, inappropriate speech
- disheveled clothing
- unkempt appearance

**SPEECH**

- slurred, thick
- incoherent
- exaggerated enunciation
- loud, boisterous
- rapid, pressured
- excessively talkative

**BODY ODORS**

- alcohol
- marijuana

Other observations: \_\_\_\_\_

\_\_\_\_\_  
Supervisor Name (*print or type*)

\_\_\_\_\_  
Supervisors Signature

\_\_\_\_\_  
Date

Additional witnesses (optional)

\_\_\_\_\_  
Witness Name (*print or type*)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**TEST DETERMINATION**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> DOT      <input type="checkbox"/> NON-DOT</li> <li><input type="checkbox"/> Reasonable Suspicion Alcohol Test</li> <li><input type="checkbox"/> Reasonable Suspicion Drug Test</li> <li><input type="checkbox"/> No Test Required</li> <li><input type="checkbox"/> Employee Refused Test</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> NO Test Conducted</li> <li><input type="checkbox"/> 8 hours elapsed for alcohol test</li> <li><input type="checkbox"/> 32 hours elapsed for drug test</li> <li><input type="checkbox"/> Employee transported for medical care</li> <li><input type="checkbox"/> Other (explain): _____</li> </ul> |
|--|---|

Employee transported to collection site by: \_\_\_\_\_

Time of Transport: \_\_\_\_\_ a.m. / p.m. Collection Facility: \_\_\_\_\_

# State of Tennessee

## Drug Collection / BAT Request Form

*Supervisor must send completed copy of this form and send an Alere Drug Testing Custody Control form with donor to collection facility*

<b>Employee's Name:</b> _____	<b>Employee #:</b> _____	<b>Date:</b> _____
<b>State Dept/Region/Location:</b> _____		
<b>Address:</b> TN Dept of Transportation; Human Resources, Ste. 400, James K Polk Building; 505 Deaderick Street, Nashville, TN 37243-0327		
<b>Contact:</b> Amy Earheart or Heather Stanford at 615-741-3461		

**Check all services to be performed and mark the reason for the testing here:**

***Services to Perform:***

***Reason for Test:***

Drug Collection DOT \_\_\_

\_\_\_ Pre-Employment

Drug Collection Non-DOT \_\_\_

\_\_\_ Random

Breath Alcohol DOT \_\_\_

\_\_\_ Reasonable Suspicion

Breath Alcohol Non-DOT \_\_\_

\_\_\_ Post -Accident

\_\_\_ ***Return to Duty (Direct Observation Required)***

\_\_\_ ***Follow-Up (Direct Observation Required)***

\_\_\_ Other

### **COLLECTOR, BAT & BILLING INSTRUCTIONS:**

- If Donor shows up without an ***Alere*** Custody form, please call NTS at 615-353-1888 immediately!
- Fax MRO copy of custody form to 615-356-1890 on the same day as collection takes place
- ***Please scan & e-mail (.pdf) Employer Copies of Drug Testing and/or Breath Testing forms to:***  
*Amy.Earheart@tn.gov and Heather.Stanford@tn.gov*
- Please call Positive Breath Alcohol Results, notification of shy bladder, shy lung, refusal to test or any special situations to: ***Amy Earheart at 615-741-3461***

*Please contact NTS Staff or Dr. Elam at 615-353-1888 with any questions or problems regarding a drug collection Or Breath Alcohol Test.*

### **BILLING FOR DRUG COLLECTIONS AND BREATH ALCOHOL TESTING SHOULD GO TO:**

NATIONAL TOXICOLOGY SPECIALISTS  
1425 ELM HILL PIKE  
NASHVILLE, TN 37210

ATTN: TIM SHOAF, ACCTS PAYABLE  
PHONE: 615-353-1888  
FAX: 615-356-1890

***After 5:00 P.M. CST please call 615-353-1888 (press 1 for immediate assistance)***

5343111491

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

1111 Newton Street, Gretna, LA 70053 | Phone: 504-361-8989 | Fax: 504-361-8298



58656531

AIRBILL NUMBER

LAB NUMBER

SPECIMEN ID NUMBER 58656531

STEP 1: To be completed by Collector or Employer Representative

A. Employer Name, Address, ID No.

DOT-REGION

Facility Number 193675

B. MRO Name, Address, Phone No., and Fax No.

DRS ELAM, GREG & CHANNELL, CA  
NATIONAL TOXICOLOGY SPECIALIS  
1425 ELM HILL PIKE  
NASHVILLE, TN 37210  
(615) 353-1888 (615) 356-1890

C. Donor SSN or Employee I.D. No.:

D. Specify Testing Authority:  HHS  NRC  DOT - Specify DOT Agency:  FMCSA  FAA  FRA  FTA  PHMSA  USCG

E. 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:

Collector Phone No.  
Collector Fax No.:

Collector Number

STEP 2: To be completed by Collector (Make Remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Is temperature between 90° and 100°F?  Yes  No, Enter Remark Collection:  Split  Single  None Provided, Enter Remark  Observed, Enter Remark

STEP 3: Collector affixes bottle seal(s) to bottle(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 on the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service in accordance with applicable Federal requirements.

SPECIMEN BOTTLE(S) RELEASED TO:

PRINT Collector Name (First, MI, Last)

Date Collected (Mo/Dy/Yr)

X Signature of Collector

Time Collected:  AM  PM

Name of Delivery Service

Received at Lab or IITF:

X Signature of Accessioner

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

Date (Mo/Dy/Yr)

Primary Specimen Bottle Seal Intact?  Yes  No If No, enter remark in Step 5A.

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5A: Primary Specimen Report to be completed by Test Facility

NEGATIVE  POSITIVE for:  Marijuana Metabolite (THCA)  6-Acetylmorphine  Methamphetamine  MDMA  DILUTE  Cocaine Metabolite (BZE)  Morphine  Amphetamine  MDA  REJECTED  ADULTERATED  PCP  Codeine  MDEA  SUBSTITUTED  INVALID RESULT

Remarks:

Test Facility (if different from above):

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Federal requirements.

X Signature of Certifying Technician/Scientist

PRINT Certifying Technician/Scientist Name (First, MI, Last)

Date (Mo/Dy/Yr)

STEP 5B: To be completed by Split Testing Laboratory

RECONFIRMED  FAILED TO RECONFIRM - REASON:

Laboratory Name

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Federal requirements.

Laboratory Address

X Signature of Certifying Scientist

PRINT Certifying Scientist Name

Date (Mo/Dy/Yr)

PEEL SPECIMEN ID NO. PEEL SPECIMEN ID NO.



SPECIMEN ID NO.

A



58656531 SPECIMEN BOTTLE SEAL

Date (Mo./Day/Yr.)

Donor's Initials



SPECIMEN ID NO.

B (SPLIT)



58656531 SPECIMEN BOTTLE SEAL

Date (Mo./Day/Yr.)

Donor's Initials

## Instructions for Completing the Federal Drug Testing Custody and Control Form

*When making entries, use black or blue ink pen and press firmly. As the field requires, enter one character per box or make a clear "X" to indicate a selection among multiple choices.*

Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory is on the top of the CCF and that the Specimen ID number on the top of the CCF matches the Specimen ID on the labels at the bottom of the form.

### STEP 1:

- Collector ensures that the required information is in STEP 1. Collector ensures a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee ID 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 of 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 of STEP 2 and takes action as required.

### STEP 2:

- Collector checks specimen temperature within 4 minutes of 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 of 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 of the form, and distributes the 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 seal(s) on the specimen bottle(s).
- Collector dates the specimen bottle label seal(s) after placement on the specimen bottle(s).
- Donor initials the specimen bottle label seal(s) after placement on the specimen bottle(s).
- Collector turns to Copy 2 (Medical Review Officer Copy) of the form 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 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 identify 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.

1654301820

NON-FEDERAL FOUR-PART DRUG TESTING CUSTODY AND CONTROL FORM

1045154/1002661

Alere

1111 Newton St., Gretna, LA 70053  
450 Southlake Blvd., Richmond, VA 23236  
Phone: 800.433.3823 | Fax: 504.361.8298

Airbill / Courier Tracking Number



201937568

Specimen ID 201937568

STEP 1: TO BE COMPLETED by Collector or Employer/Client Representative

A. Employer/Client Name, Address, Phone, & Fax:

TDOT-REGION

Facility Number

193675

B. MRO Name, Address, Phone, & Fax:

DRS ELAN, GREG & CHANNELL, CAL  
NATIONAL TOXICOLOGY SPECIALIST  
2425 ELD HILL PIKE  
NASHVILLE, TN 37210  
(615) 352-1888 (615) 356-2890

C. Name/ID:

PRINT ALL IN CAPS for Donor Name (Last Name, First Name MI); leave space between names/ID/Auxiliary Data.

D. Donor SSN or Employee ID No.:

E. Daytime Phone No.:

F. Evening Phone No.:

G. Reason for Test:  Pre-Employment  Random  Reasonable Suspicion/Cause  Post Accident  Return to Duty  Follow-up  Other

H. Panel: If a panel is not selected below, Alere will use the default for the Facility listed above. See back copy 4 for additional panel instructions.

A Primary Panel  B Default Panel  C  D  E  F Other: (write in panel number)

I. Collection Site Name & Address:

Collector Phone No.:

TO BE COMPLETED COLLECTOR  
ADDRESS  
CITY: ST ZIP

615-356-1888  
615-356-2890

Collector Number  
55406

STEP 2: TO BE COMPLETED by Collector - Within 4 minutes, read temperature of specimen.

Within range?  Yes 90°-100°F / 32°-38°C  No  Below 90°F / 32°C  Above 100°F / 38°C

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 Donor

I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen container used was sealed with tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen container is correct.

X

Signature of Donor

Donor Date of Birth (Mo./Day/Yr.)

Date:

STEP 5: CHAIN OF CUSTODY - Initialed by Collector and completed by Laboratory

I certify that the specimen given to me by the donor identified above was collected, labeled, sealed, and released in accordance with applicable requirements.

PRINT Collector Name (First, MI, Last)

Date Collected (Mo./Day/Yr.)

Specimen Bottle(s) Released to: COURIER

X  
Signature of Collector

Time Collected:  AM  PM

Service Transferring Specimen to Lab

STEP 6: TO BE COMPLETED by Lab

RECEIVED AT LAB:

X  
Signature of Accessioner PRINT Accessioner Name (First MI Last)

LAB NUMBER

Date (Mo/Dy/Yr) Primary Specimen Seal Intact?  Yes  No, Enter Remark Specimen(s) Released to: TEMPORARY STORAGE

Remarks:



SPECIMEN ID NO. 201937568

A



Date (Mo./Day/Yr.)

201937568

SPECIMEN BOTTLE SEAL

Donor's Initials



SPECIMEN ID NO. 201937568

B (SPLIT)



Date (Mo./Day/Yr.)

201937568

SPECIMEN BOTTLE SEAL

Donor's Initials

1101 REV 07/2013

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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 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 identify 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.

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**TDOT MEDICATION APPROVAL FORM**

**EMPLOYEE COMPLETES THIS SECTION:**

EMPLOYEE NAME \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYEE ID # \_\_\_\_\_ JOB TITLE \_\_\_\_\_

JOB DESCRIPTION \_\_\_\_\_

REGION \_\_\_\_\_ WORK PHONE NUMBER: \_\_\_\_\_ OTHER NUMBER \_\_\_\_\_

Name of Drug	Date Prescribed	Date Approval Expires	Restrictions/Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The information provided in this Medication Approval Form is true and correct to the best of my knowledge. I understand and will comply with the prescribed use of these medications and their restrictions while working.

\_\_\_\_\_  
Employee Signature / Employee ID # / Phone Number Date

**EMPLOYEE'S HEALTH CARE PRACTITIONER COMPLETES THIS SECTION:**

Please complete this form so that your patient can work in his/her Tennessee Department of Transportation safety sensitive job. By signing below, you are acknowledging that you are aware of this employee's job duty requirements and that the prescribed medication(s) currently being taken will not adversely impair performance or endanger the safety of this individual, co-worker, or the public. Please indicate below what, if any, restrictions should be placed upon the time between when the medication is taken and the time the individual can safely perform his/her job duties.

**Medication Employee is Currently Taking:**

Name of Drug	Date Prescribed	Date Approval Expires	Restrictions/Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Signed Date

**Please Print Name, Address and Phone Number Below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**AWARENESS STATEMENT REGARDING VOLUNTARILY OBTAINING A COMMERCIAL  
DRIVER'S LICENSE**

I \_\_\_\_\_, an employee of the Tennessee Department of Transportation, understanding my current position does not require me to obtain a Commercial Driver's License (CDL), have voluntarily obtained a CDL in order to assist the Department with job responsibilities that require a CDL during periods when additional assistance may be needed.

CDL requirements have been explained to me as follows:

1. Positions requiring a commercial driver's license (CDL) – All TDOT Operations Technician, TDOT Operations Technician Senior, TDOT Operations Technician Supervisor, TDOT Technician, TDOT Technician Senior, TDOT Technician Supervisor, Equipment Mechanic, Equipment Mechanic Supervisor 1, and Automotive Master Mechanic titles for which a CDL is required.
2. All CDL license holders will be required to obtain a Class B license at age 18 and all subsequent licenses building toward the Class A as allowed by State Law as shown in Section 1.4 of the current Tennessee Department of Safety and Homeland Security Commercial Driver License Manual. At age 21, a Class A license with an N Endorsement will be required (a 57 Restriction is allowable). The Department currently assists employees in obtaining these licenses, but does not cover any related cost.
3. All employees who perform job responsibilities requiring a CDL, including employees who have voluntarily obtained a CDL in order to assist the Department with such job responsibilities, are governed by Policy Number 230-18, CDL and Safety-Sensitive Employees Alcohol and Drug Testing.

I understand that in volunteering to obtain a CDL so as to assist the Department with job responsibilities requiring a CDL that are outside my current job responsibilities, I will be subject to Policy Number 230-18, CDL and Safety-Sensitive Employees Alcohol and Drug Testing, including alcohol and drug testing as provided in this Policy. I further realize that disciplinary actions, up to and including dismissal from State service, may be taken against in me if I fail to comply with the Policy.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_