

REASONABLE SUSPICION TESTING CHECKLIST

Employee Name: _____ Employee Job Title: _____
 Facility: _____ Location of Event: _____
 Observation Date: _____ Time: _____ a.m./p.m.
 Was employee performing a safety-sensitive duty? 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- ☐ Depressed, withdrawn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

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> DOT | <input type="checkbox"/> NON-DOT | <input type="checkbox"/> NO Test Conducted |
| <input type="checkbox"/> Reasonable Suspicion Alcohol Test | | <input type="checkbox"/> 8 hours elapsed for alcohol test |
| <input type="checkbox"/> Reasonable Suspicion Drug Test | | <input type="checkbox"/> 32 hours elapsed for drug test |
| <input type="checkbox"/> No Test Required | | <input type="checkbox"/> Employee transported for medical care |
| <input type="checkbox"/> Employee Refused Test | | <input type="checkbox"/> Other (explain): _____ |

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 Alere Drug Testing Custody and Control form with donor to collection facility

Employee's Name: _____	Employee #: _____	Date: _____
State Dept/Location: _____		
Address: TN Dept of Transportation; Human Resources, Ste. 400, James K Polk Building; 505 Deaderick Street, Nashville, TN 37243-0327		
Contact: 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:

Drug Collection DOT _____
 Drug Collection Non-DOT _____

 Breath Alcohol DOT _____
 Breath Alcohol Non-DOT _____

*Reason For Test:

_____ Pre-Employment
 _____ Random
 _____ Reasonable Suspicion
 _____ Post -Accident
 _____ **Return to Duty (MANDATORY OBSERVED)**
 _____ **Follow-Up (MANDATORY OBSERVED)**
 _____ 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

National Toxicology Specialists 1425 Elm Hill Pike Nashville, TN 37210 615-353-1888

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

Alere



LAB NUMBER

AIRBILL NUMBER

SPECIMEN ID NUMBER 58656531

STEP 1: To be completed by Collector or Employer Representative

A. Employer Name, Address, ID No.

 DOT-REGION 3
 505 DEADERICK ST; 4TH FLOOR

 NASHVILLE, TN 37243
 615-532-3781 615-253-1477

 Facility Number
 193675

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

 DRS ELAM, GREG & CHANNELL, CA
 NATIONAL TOXICOLOGY SPECIALISTS
 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 ☐ USCGE. 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

Remarks:

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 in 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 ☐ NoIf 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
☐ PCP ☐ Codeine ☐ MDEA
☐ REJECTED ☐ ADULTERATED ☐ 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)

P
E
E
L
P
E
E
L

SPECIMEN ID NO.

A

CENTER
OVER
CAP58656531
SPECIMEN BOTTLE
SEAL

Date (Mo/Day/Yr.)

Donor's Initials



SPECIMEN ID NO.

B

(SPLIT)

CENTER
OVER
CAP58656531
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 identifying 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



Specimen ID 201937568

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

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

TDOT-REGION 3
 505 DEADERICK ST, 4TH FLOOR
 NASHVILLE, TN 37243
 615-532-3781 615-253-1477

Facility Number

193675

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

DRS ELAN, GREG & CHANNELL, CAL
 NATIONAL TOXICOLOGY SPECIALIST
 1425 ELD HILL PIKE
 NASHVILLE, TN 37210
 (615) 352-1888 (615) 356-1890

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
☐ B Default
☐ C Panel

☐ Other:
 (write in panel
 number)

I. Collection Site Name & Address:

Collector Phone No.:

TO BE COMPLETED COLLECTOR
 ADDRESS
 CITY, ST ZIP

615-356-1888
 615-356-1890

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 ☐ Oral Fluid, temperature not applicable ☐ Split Specimen ☐ No ☐ Yes ☐ Observed

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

Date:

Donor

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

STEP 5: CHAIN OF CUSTODY - Initiated 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.)

Time

Collected:

☐ AM☐ PM

Specimen Bottle(s) Released to:

COURIER

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)

Date (Mo/Dy/Yr)

Primary Specimen Seal Intact?
☐ Yes ☐ No, Enter Remark

Specimen(s) Released to:
 TEMPORARY STORAGE

Remarks:

LAB NUMBER



SPECIMEN ID NO. 201937568

A



B
 (SPLIT)



SPECIMEN ID NO. 201937568

Date (Mo./Day/Yr.)

201937568

SPECIMEN BOTTLE
 SEAL

Donor's Initials

Date (Mo./Day/Yr.)

201937568

SPECIMEN BOTTLE
 SEAL

Donor's Initials

1101 REV 07/2013

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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.

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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.

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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.

Signed _____ 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 District Assistant, TDOT Technician, TDOT Technician Senior, 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 _____