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- ☐ Depressed, withdrawn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
- ☐ **DOT** ☐ **NON-DOT**
- ☐ Reasonable Suspicion Alcohol Test
- ☐ Reasonable Suspicion Drug Test
- ☐ No Test Required
- ☐ Employee Refused Test
- ☐ NO Test Conducted
- ☐ 8 hours elapsed for alcohol test
- ☐ 32 hours elapsed for drug test
- ☐ Employee transported for medical care
- ☐ Other (explain): _____

Employee transported to collection site by: _____
Time of Transport: _____ a.m. / p.m. Collection Facility: _____

National Toxicology Specialists - 1425 Elm Hill Pike, Nashville TN 37210 - Phone: 615-353-1888 - Fax: 615-356-1890

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

Employee's Name: _____ **Employee #:** _____ **Date:** _____
State Dept/Region/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:	*Reason for Test*:
Drug Collection DOT___	____ Pre-Employment
Drug Collection Non-DOT___	____ Random
	____ Reasonable Suspicion
Breath Alcohol DOT___	____ Post -Accident
Breath Alcohol Non-DOT___	____ *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)

1797254263

Alere

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

☐ 1111 Newton Street, Gretna, LA 70053
☐ 450 Southlake Boulevard, Richmond, VA 23236
Phone: 800.433.3823
Fax: 504.361.8298

1819176/1587346

513843281

Courier Tracking Number

LAB NUMBER

OMB NO. 0930-0158

STEP 1: To be completed by Collector or Employer Representative

Specimen ID Number 513843281

A. Employer Name, Address, ID No.

TDOT-
SGB BEADERICK ST;4TH FLOOR
NASHVILLE, TN 37243
615-532-3781 615-253-1477

Facility Number: 19196

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

DRS ELAM, GREG & CHANNELL, CAL
NATIONAL TOXICOLOGY SPECIALIST
1425 ELM HILL PIKE
NASHVILLE, TN 37210
615-353-1888 615-356-1890

C. Donor SSN or Employee ID No.:

Location Code: (optional)

D. Specify Testing Authority: ☐ HHS ☐ NRC 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:

TO BE COMPLETED BY COLLECTOR

Collector Phone & Fax: (Write phone number in boxes if not pre-printed.)

PH:
FX:

Collector Number: 60161

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 noted in accordance with applicable Federal requirements.

PRINT Collector Name (First, MI, Last)

Date Collected (Mo/Dy/Yr)

X
Signature of Collector

Time Collected: ☐ AM ☐ PM

SPECIMEN BOTTLE(S) RELEASED TO:

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 (Δ9-THCA) ☐ Methamphetamine ☐ MDMA ☐ 6-Acetylmorphine ☐ OXYC ☐ HYC
☐ DILUTE ☐ Cocaine Metabolite (BZE) ☐ Amphetamine ☐ MDA ☐ Morphine ☐ OXYM ☐ HYM
☐ PCP ☐ Codeine

☐ **REJECTED FOR TESTING** ☐ **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

Laboratory Name

Laboratory Address

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON:

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 Scientist

PRINT Certifying Scientist Name

Date (Mo/Dy/Yr)

SPECIMEN ID NO. 513843281

A

CENTER OVER CAP

Date (Mo./Day/Yr.)

513843281 SPECIMEN BOTTLE SEAL

Donor's Initials

SPECIMEN ID NO. 513843281

B (SPLIT)

CENTER OVER CAP

Date (Mo./Day/Yr.)

513843281 SPECIMEN BOTTLE SEAL

Donor's Initials

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 ELAM, GREG & CHANNELL, CAL
NATIONAL TOXICOLOGY SPECIALIST
1425 ELM HILL PIKE
NASHVILLE, TN 37210
(615) 358-1888 (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.

Sub Acct: (optional)

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 Default Panel ☐ B ☐ C ☐ D ☐ E ☐ Other: (write in panel number)

I. Collection Site Name & Address:
TO BE COMPLETED COLLECTOR
ADDRESS
CITY, ST ZIP

Collector Phone No.: (Enter here if not printed below)
615-358-1888
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 seals(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 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 - 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.) / /

X Signature of Collector

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

SAMPLE

SPECIMEN ID NO. 201937568

A

CENTER OVER CAP A

Date (Mo./Day/Yr.)

Donor's Initials

201937568 SPECIMEN BOTTLE SEAL

SPECIMEN ID NO. 201937568

B (SPLIT)

CENTER OVER CAP B

Date (Mo./Day/Yr.)

Donor's Initials

201937568 SPECIMEN BOTTLE SEAL

1101 REV 07.2013

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 & ID Number_____Date _____