



**Human Performance Attachment**

**DOT Post-Crash Testing Results, Motorcoach Driver**

**Biloxi, MS**

**HWY17MH010**

(5 pages)

From:

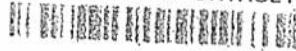


402 W County Rd D  
St. Paul, MN 55112

03/07/2017 17:44

#001 P.003/003

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



Y31148423

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No.  
SRH DOT Echotaxis & Charlers  
5124 SW Green Oaks Blvd Ste D  
Arlington, TX 76017 9445701  
ph 800-224-9551

B. MRO Name, Address, Phone No. and Fax No.  
Carled Capin / Acy / Ince  
SRHS CLINICS-PASCAGOULA  
2819 DENNY AVE  
PASCAGOULA, MS 39581  
PH 768-762-3444 FX 228-762-3427

C. Donor SSN or Employee I.D. No. 569043265

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: SINGING RIVER HOSPITAL  
2809 DENNY AVE PASCAGOULA MS 39581  
Collector Phone No. 228 907 5166 Collector Fax No. 228 907 5053

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F?  Yes  No, Enter Remark \_\_\_\_\_  
Collection:  Split  Single  None Provided, Enter Remark \_\_\_\_\_  
REMARKS: Observer - Tyler Armstrong, RN  
57006

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)

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  
Time of Collection 17:10 AM  
Date 03/07/2017  
SPECIMEN BOTTLE(S) RELEASED TO:  
 FedEX  Local Courier  
 Other

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

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 back of this form is true and correct.  
X \_\_\_\_\_  
Signature of Donor  
Daytime Phone No. \_\_\_\_\_ Evening Phone No. ( ) \_\_\_\_\_ Date of Birth 3/7/17  
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 5: COMPLETED BY DONOR

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN  
In accordance with applicable Federal requirements, my verification is:  
 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: \_\_\_\_\_  TEST CANCELLED  
 FAILED TO RECONFIRM for: \_\_\_\_\_  
REMARKS: \_\_\_\_\_  
X \_\_\_\_\_  
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) \_\_\_\_\_ Date (Mo./Day/Yr.) \_\_\_\_\_

MS 10-0030-013

Form 15 (3/13) MS 013

**ATTENTION:**

Chris Jarrard  
ECHO Tours and Charters, LP-DOT  
9314 W Jefferson Blvd , # 295  
Dallas, TX 75211

Participant [REDACTED]  
Participant ID [REDACTED]  
SSN [REDACTED]

**Results of DOT Controlled Substance Test**

Record Status: Negative  
Test Type: Post-Accident - DOT  
Collection Date/Time: 03/07/2017 5:10 PM  
Batch ID: 20170309  
Specimen ID: Y31148423  
Date COC Received: 03/09/2017  
Sample Type: Urine  
Test Panel: 5-Substances

Laboratory: Med Tox  
402 W County Rd D  
St Paul, MN 55112  
Collection Site: Singing River Hospital  
2809 Denny Ave.  
Pascagoula, MS 39581  
Specimen Collector: Virginia Moseley  
DOT Admin(s): FMCSA

<u>Test Performed</u>	<u>Result</u>
Amphetamines	Negative
Marijuana(Cannabinoids)	Negative
Opiates	Negative

<u>Test Performed</u>	<u>Result</u>
Cocaine	Negative
Phencyclidine	Negative

This test was performed, recorded and reported in accordance with CFR 49 Part 40

[REDACTED]  
Carleo Capili, M D

3/9/2017  
Verification Date

# U.S. Department of Transportation (DOT) Alcohol Testing Form

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

**STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN**

A: Employee Name \_\_\_\_\_  
 (Print) (First, M.I., Last) \_\_\_\_\_

B: SSN or Employee ID No. \_\_\_\_\_

C: Employer Name ECHO TOURS & CHARTERS  
 Street 9314 W. JEFFERSON BLVD # 295  
 City, State, Zip DALLAS TX 75211

DER Name and Telephone No. Chris Jarrard 817,572-4114  
 DER Name DER Phone Number

D: Reason for Test:  Random  Reasonable Susps  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 3 / 7 / 17  
 Signature Date Month Day Year

**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.)  
0817 Intoxilyzer 240 0809730 16:34 16:35 .000  
 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: \_\_\_\_\_

Singing River Hospital 2809 Denny Ave  
 Alcohol Technician's Company Company Street Address  
Virginia R. Moseley Pascagoula MS 39581 809-5166  
 (PRINT) Alcohol Technician's Name (First, M.I., Last) Company City, State, Zip Phone Number  
 Signature of Alcohol Technician \_\_\_\_\_ Date 3 / 7 / 17  
 Signature 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Signature Date Month Day Year

Print Screening Results Here or Affix with  
**EVIDENCE**

Singing River Hospital  
 Pascagoula MS  
 CMI, Inc.  
 Intoxilyzer 240  
 Serial Number: 0809730

Type of Test: DOT Combination  
 Reason for Test: Post Accident  
 Screening Test#: 0217  
 Date: 03/07/2017

Operator ID#: 424470  
 Operator Name: VIRGINIA R MOSELEY  
 Operator Signature: \_\_\_\_\_

Subject Company: ECHO TOURS  
 Subject ID#: 032156  
 Subject Name: \_\_\_\_\_  
 Subject Signature: \_\_\_\_\_

Sequence	Result	Time
0217	PASS	16:34
0217	.000	16:35

Test Is Negative  
**EVIDENCE**

Print Additional Results Here or Affix With Tamper Evident Tape

Form DOT F 1380 (Rev. 5/2008)

**EMI** inc. 866-835-0690 • P/N 650528 • OMB No. 2105-0529

**COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER**

**ATTENTION:**

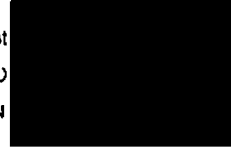
Chris Jarrard

ECHO Tours and Charters, LP-DOT

9314 W. Jefferson Blvd , # 295

Dallas, TX 75211

Participant  
Participant ID  
SSN



**Results of DOT Alcohol Test**

Record Status: Negative

Test Type: Post-Accident - DOT

Collection Date/Time: 03/07/2017 4:34 PM

Batch ID: 20170308

Specimen ID: 217

Date COC Received: 03/08/2017

Sample Type: Breath

Test Panel: Alcohol

Collection Site: Singing River Hospital

2809 Denny Ave.

Pascagoula, MS 39581

Specimen Collector: Virginia Moseley

DOT Admin(s): FMCSA

**Test Performed Result**

Alcohol Negative

This test was performed, recorded and reported in accordance with CFR 49 Part 40

