Human Performance Attachment

DOT Post-Crash Testing Results, Motorcoach Driver

Biloxi, MS

HWY17MH010

(5 pages)

From:

03/07/2017 17:44 #001 P.003/003

MEDTOX LABORATORIES, INC.
402 W County Rd D
St. Paul, MN 55112

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Y31148423

OMB No. 0930-0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE SPECIMEN ID NO. ACCESSION NO.

A. Employer Name, Address, I.D. No.
SRH DOT Echolovis & Charters
[illegible] 5612 SW Green Oaks Blvd Ste D
[illegible] Arlington, TX 76017 94N5701
[illegible] ph 800-221-9551

B. MRO Name, Address, Phone No. and Fax No.
Carlo Capili/HCV Trace
SRHS CLINICS-PASCAGOULA
2819 DENNY AVE
PASCAGOULA, MS 39581
ph 228-762-3427 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. 2288901316 Collector Fax No. 2288909505 3

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 | ☒ Observed, 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)

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.

X [redacted]
Signature of Collector

Virginia K Mosley
(PRINT) Collector's Name (First, MI, Last)

Time of Collection: 1710 ☐ AM ☒ PM

Date (Mo./Day/Yr.): 03/07/2017

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
☒ FedEX ☐ Local Courier ☐ Other

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 [illegible] is correct.

X [redacted]
Signature of Donor [redacted] 3/7/17

Daytime Phone No. [redacted] Evening Phone No. ( ) Date of Birth [redacted]
(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:

☐ NEGATIVE ☐ POSITIVE for: _____ ☐ DILUTE

☐ REFUSAL TO TEST because – check reason(s) below: ☐ TEST CANCELLED
☐ ADULTERATED (adulterant/reason): _____
☐ 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: [illegible] ☐ 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.)

Form A13 (7/13) Mfg. 8/13

COPY 2 - MEDICAL REVIEW OFFICER COPY

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

Test Performed	Result	Test Performed	Result
Amphetamines	Negative	Cocaine	Negative
Marijuana(Cannabinoids)	Negative	Phencyclidine	Negative
Opiates	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 [redacted] (Print) (First, M.I., Last)

B: SSN or Employee ID No. [redacted]

C: Employer Name: ECHO Tourist 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 Susp ☒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.

[redacted] 3 / 7 / 17
Signature of Employee — 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.)*

Test #	Testing Device Name	Device Serial # OR Lot # & Exp Date	Activation Time	Reading Time	Result
0217	Intoxilyzer 240	080973D	16:34	16:35	.000

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

REMARKS:

Singing River Hospital — Alcohol Technician's Company
2809 Denny Ave — Company Street Address
Virginia R. Moseley — (PRINT) Alcohol Technician's Name (First, M.I., Last)
Pascagoula MS 39581 — Company City, State, Zip
228 809-5166 — Phone Number
[redacted] — Signature of Alcohol Technician
3 / 7 / 17 — 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

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

Print Screening Results Here or Affix with

ENCE

Singing River Hospita
Pascagoula MS
CMI, Inc.
Intoxilyzer 240
Serial Number: 080973D

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:
[redacted]

Subject Company:
ECHO TOURS
Subject ID#: 032156
Subject Name:
[redacted]

Subject Signature:
[redacted]

Sequence	Result	Time
Diagnostics	PASS	16:34
Test# 0217	.000	16:35

Test Is Negative

EVID

Print Additional Results Here or Affix With Tamper Evident Tape

From:

ATTENTION:

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

Participant [redacted]
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