

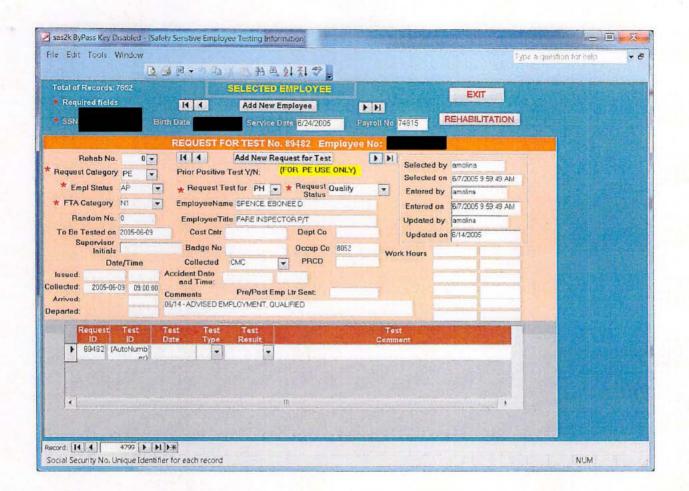
Motor Carrier Attachment 42:

MTA Transit Bus Driver Drug Testing Records

Baltimore, MD; 11/1/2016

HWY17MH007

(7 pages)



Maryland Transit Administration FEDERAL TRANSIT ADMINISTRATION REQUIRED RANDOM DRUG TEST APPOINTMENT

)-	- 6-	- D	11 /
Employee Name:	. Done	e ba	Ker
Social Security # -		1	-

Badge/Payroll#

INSTRUCTIONS TO EMPLOYEE:

- You must immediately proceed and report without delay to the appropriate collection site, *(See note on reverse) 1. for an FTA Random Drug Urinalysis Test today 3 / 9 /20/6 at 9 : 13 (AM)PM.
- You must alert the test site personnel of your arrival and present your official photo identification card. Failure to 2. provide positive photo ID is a refusal to test and will be cause for termination action.
- 3. Failure to keep this appointment for any reason, including illness, will be considered a refusal to test and will be cause for termination action.
- While you are waiting to provide a sample for your drug and/or alcohol test, you are NOT permitted to leave the 4. testing facility. You must stay within the designated waiting area; you are not permitted to go outside or beyond the entrance doors for any reason (cigarette breaks, telephone calls, fresh air, etc.). If you leave the testing site for any reason during the testing process, it will be considered a refusal to test and will be cause for termination action.

Employee Signature

3/9/14

INSTRUCTIONS TO SUPERVISOR:

- Establish the appointment time by determining the minimum travel time for the employee to arrive at the testing site in the most immediate and direct route. Complete the MTA Supervisor's Section.
- Notify the employee of their selection and direct them to immediately proceed to the collection site.
- 3. Separate and place the supervisor's copy in the employee's department file.
- Hand the employee pages 1,2,3. Instruct the employee to provide the collection site personnel with the 4 OHR/Medical Services-Page 1 (White) copy; Collection Site-Page 2 (Green) copy; and Employee-Page 3 (Yellow) copy. The employee must return his copy completed by the collection site for travel time payment.
- You must investigate and submit a written report to your Division Director and OHR/Medical Services 5. Section for any employee who had a recorded travel time in excess of one (1) hour.

SUPERVISOR'S SECTION AND ATTESTATION:

I have delivered a copy of this appointment form by hand to the above named employee.
 Considering all factors, it will take the employee approximately { bo } minutes to arrive to the testing site

Considering all factors, it will take the chips of a production of the considering all factors, it will take the chips of a product utilizing the most immediate and direct route.

The employee's work schedule for today is { 1.22 AM/PM to 9.58 AM/PM} and { 2.35 AM/PM to 4.09 AM/PM }

A Supervisor's Signature | 3 / 9 / 20 / 6

Time Form issued to Emp. Date

MTA Supervisor's Signature

TESTING SITE SECTION:

Complete the employee arrival and departure times on pages 1,2,3. Give the Employee the completed page 3 (Yellow) copy. Attach the OHR/Medical Services copy (top-White) to the Employer's Copy of the Chain of Custody

Employee arrived at:

8:58AM/PM 9:10 (M/PM 9:15 AM/PM
Arrival Time Specimen Collection Departure Time

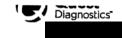
Reverse Side: General Employee Information

Distribution:

HRD/Medical Services - White Copy

Collection Site - Green Copy

Employee - Yellow Copy Department File - Pink Copy



10528624 5920450 SPECIMEN ID NO. 3720470

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESI	ENTATIVE LAB ACCESSION NO.
A. Employer Name, Address, I.D. No.	B. MRO Name, Address, Phone No. and Fax NS/MUDIC FOR
CARVEARD (MARKE) AND N	NURSEMBLE ON-TIPO SURVICES
STOPE SPO ENGAZORR	PAUL TEVNUR HU
SAPAS PARK STELLS	1430 S HAIH \$1
SA 14BTRE -UN 21762	SALL LAKE CITY AT MALES
* 18 430 7: 2-3-61 PAR 430-349 1916	78 866 249 4675 (6° 86), 756 9913
and the state of t	(a. aye 247 4.77) (b. 50), 155 27; 7
C. Donor SSN or Employee I.D. No.	
D. Specify Testing Authority: HHS NRC DOT - Specify DOT Age	ency: □FMCSA □FAA □FRA X FTA □PHMSA □USCG
E. Reason for Test: Pre-amployment Random Reasonable Suspicion/Cause	Post Accident Return to Duty Follow-up Other (specify)
F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP	C & COC Only Other (specify)
· 💢 453044 (file drug	Fanta, Wis
are a constant of the	
G. Collection Site Name: Concentra Medical Center	Collection Site Code:
G. Collection Site Name: 100 S. Charles St. Ste 150 Address: Baltimore, MD 21201	MD 151 Collector Phone No.:
340 3EO 3010	IAID IO.
City, State and 21p. Fax: 410-539-7023	Collector Fax No.:
	propriate) Collector reads specimen temperature within 4 minutes.
Temperature between 90° and 100° F2 Yes 🔲 No, Enter Remark Collection: 🗡	Split Single None Provided, Enter Remark Dbserved, (Enter Remark)
The state of the s	
TED 4. CUAIN OF CHETODY INITIATED BY COLLECTOR AND	seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy
I cartify that the specimen tilven to me by the control ideal in the cartification section on Co collected, leasting sealed, and released to the Polivery Service noted in accordance with applic	py2 of this form was SPECIMEN BOTTLE(S) RELEASED TO:
collected, labeled, stalled, and released to the Delivery Service noted in accordance with applic	cable Federal requirements. Quest Diagnostics Courier
X	☐ FedEx
Signature of Collector - C 14	Otto D Other
2/1/4	7 9.70 PM
(Print) Collector's Name (First, MI, Last) Date (Mo./Day/Yr.	Time of Collection Name of Delivery Service
TEP 5: COMPLETED BY DONOR	
I certify that I provided my urine specimen to the collector; that I have not adult in my presence and that the information provided on this form and on the lab	Iterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal nel affixed to each specimen bottle is correct.
1 1 1	
v C	TITION PAKER 319 116
Signature of Donor	(PRINT) Depor's Name (First, Mi, Lest) Date (Mo./Day/Yr.)
	1 1 1 30 200
Daytime Phone No. 1 Evening Phone No. 1	Ma Day Ve
After the Medical Review Officer receives the test results for the spec	imen identified by this form, he/she may contact you to ask about prescriptions
and over-the-counter medications you may have taken. Therefore, you	u 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 s	cimen identified by this form, he/she may contact you to ask about prescriptions u may want to make a list of those medications for your own records. THIS LIST reparate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE ORM, TAKE COPY 5 WITH YOU.
TEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMAR	RY 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):	<u> </u>
SUBSTITUTED	
□ OTHER	
REMARKS:	
the state of the s	p
X	
Signature of Medical Review Officer (Pi	RINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)
TEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT S	
In accordance with applicable Federal requirements, my verification for sp	
RECONFIRMED for:	TEST CANCELLED
FAILED TO RECONFIRM for:	
REMARKS:	
x	1 1
<u> </u>	STREET SALES Devices Colleges a Name (First All Last)





CONCENTRA 118 PORTSMOUTH AVE BLDG B UNIT 202 STRATHAM, NH 03885 (603) 929-1648

TO: MARYLAND TRANSIT ADMIN MDOT (SMD) 6 SAINT PAUL ST STE FL 5 BALTIMORE, MD 21202

MARYLAND TRANSIT ADMIN MDOT (SMD) 6 SAINT PAUL ST STE FL 5 BALTIMORE, MD 21202

Random

5920450

055408L

03/09/2016

03/10/2016

03/10/2016

Paul Teynor, MD

Time: 0910

Time: 1119

Time: 1044

Medical Review Officer Report

-Confidential-

This is a notification of a controlled substance test result on:

Individual Tested: Donor ID:

Collection Site:

EBONEE BAKER

Concentra Baltimore 2114

Suite #150

Baltimore, MD 21201 (410) 752 - 3010

Laboratory:

100 South Charles Street

QUEST DIAGNOSTICS

Reason for Test:

Specimen ID#: Date of Collection: Lab Accession#:

Lab Reported Date: MRO:

MRO Received Date: MRO Report Date:

MRO Date CCF2:

Specimen Type: Urine Drug Panel: 45304N

Substances included in test profile:

Dru	q	Screen	Confirm	Drug	Screen	Confirm
HE	ROIN	10	10	Adulterants		
am	hetamines	500	250	Cocaine	150	100
MD	A	500	250	Nitrite		
Opi	ates	2000	2000	Phencyclidine	25	25
Ma	ijuana	50	15			

This controlled substance test was conducted in accordance with 49 CFR Part 40.

The verified result is:

*** Negative ***

Comments:

Paul Teynor, MD

03/11/2016

Maryland Transit Administration FEDERAL TRANSIT ADMINISTRATION REQUIRED RANDOM ALCOHOL TEST APPOINTMENT

Employee Name:	Ebo	nee	2 Baker Bady	Badge/Payroll#	THE
Social Security #					

INSTRUCTIONS TO EMPLOYEE:

You must immediately proceed and report without delay to the appropriate collection site, *(See note on reverse) for an FTA Random Alcohol Test today 7 113 12016, at 9 : 05 (AM/PM.

You must alert the test site personnel of your arrival and present your official photo identification card. Failure to provide positive photo ID is a refusal to test and will be cause for termination action.

Failure to keep this appointment for any reason, including illness, will be considered a refusal to test and will be cause for termination action.

While you are waiting to provide a sample for your drug and/or alcohol test, you are NOT permitted to leave the testing facility. You must stay within the designated waiting area; you are not permitted to go outside or beyond the entrance doors for any reason (cigarette breaks, telephone calls, fresh air, etc.). If you leave the testing site for any reason during the testing process, it will be considered a refusal to test and will be cause for termination action.

7/13/16

Employee Signature

INSTRUCTIONS TO SUPERVISOR:

Establish the appointment time by determining the minimum travel time for the employee to arrive at the testing site in the most immediate and direct route. Complete the MTA Supervisor's Section.

Notify the employee of their selection and direct them to immediately proceed to the collection site. 2.

3. Separate and place the supervisor's copy in the employee's department file.

Hand the employee pages 1,2,3. Instruct the employee to provide the collection site personnel with the 4. OHR/Medical Services-Page 1 (White) copy; Collection Site-Page 2 (Green) copy; and Employee-Page 3 (Yellow) copy. The employee must return his copy completed by the collection site for travel time payment.

If the Alcohol Test Result is .02 or greater the employee may not return to work, and you must contact the 5. Medical Services Section. If the result is .04 or greater the employee must be offered transportation home. When transportation is offered, please indicate the employee's response. l accepted |

You must investigate and submit a written report to your Division Director and OHR/Medical Services Section for any employee who had a recorded travel time in excess of one (1) hour.

SUPERVISOR'S SECTION AND ATTESTATION:

1. I have delivered a copy of this appointment form by hand to the above named employee.

Considering all factors, it will take the employee approximately [60] minutes to arrive to the testing site utilizing the most immediate and direct route. The employee's work schedule for today is { \$:04 AM/PM to ___AM/PM} and { ___AM/PM to ___YOU AM/[M]}

Phone # St. 7682 8:05 (AM/PM Time Form Issued to Emp. Date

7/13/20/16

MTA Supervisor's Signature

TESTING SITE SECTION:

If the employee's test result is .02 or greater, please advise the supervisor at the phone number above.

Complete the employee arrival and departure times on pages 1,2,3. Give the Employee the completed page 3 (Yellow) copy. Attach the OHR/Medical Services copy (top-White) to the US Department of Transportation Alcohol

Testing Form (ATF) Employee arrived at:

7/13/20/6

S: 59 M/PM Arrival Time

Reverse Side: Distribution:

General Employee Information

Date

HRD/Medical Services - White Copy Collection Site - Green Copy

Employee Yellow Copy Department File Pink Copy

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

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

		<u></u>			
Step 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN					
A: Employee Name	bonee	Baker			
7	(Print)	(First, M.I., Last)	4815		
B: SSN or Employee ID No.	* 4 244 A		7013		
C: Employer Name	MIA				
Street	10 St 1	Paul St. 1	=15		
City, State, Zip	8011	<u> </u>	2:020		
	Buston	ore, MD a	31202		
DER Name and Telephone No.	Patricia.	tomson			
resepuone 140.	DER Name	JUTTUROT	DER Phone Number		
- do					
D: Reason for Test: Randon	Reasonable Susp	Post-Accident Return to	Duty □ Follow-up □ Pre-employment		
STEP 2: TO BE COMPLETED	D BY EMPLOYEE				
			ĺ		
I certify that I am about to subridentifying information provide	nit to alcohol testing real	quired by US Department of	Transportation regulations and that the		
browner browner	on the form is true at	in collect	A77 12 11		
Conner 10	-		0.1.13.16		
Signature of Employee			Date Month Day Year		
D. A. St. B. March C. B. C.					
STEP 3: TO BE COMPLETED	BY ALCOHOL TECH	INICIAN			
(If the technician conducting the	e screening test is not th	e same technician who will h	pe conducting the confirmation test,		
each technician must complete t	their own form.) I certi	ly that I have conducted alco	ohol testing on the above named		
individual in accordance with th	te procedures establishe	ed in the US Department of	Fransportation regulation, 49 CFR Part		
40, that I am qualified to operat			1		
TECHNICIAN: KAT [STT DEVICE:	SALIVA PREATH*	15-Minute Wait: ☐ Yes 🔊 🛪 🖟 💮 o		
SCOPPNING TEST: (For DE	FATH DEVICES	the man helm out if the te	ation desired to the state of the state of		
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 # OP Lo	t # & Exp Date Activation	Time Reading Time Result		
-					
CONFIRMATION TEST: Resu	lts <u>MUST</u> be affixed to e	ach copy of this form or printe	d directly onto the form.		
REMARKS:					
					
			,		
Composition		100 & CO	Le 87, Ste150		
Alcohol Technician's Company		Sompany Street Addres			
LOUISAMIT	SULL	Balt MB 212	207		
(PRINT) Alcohol Technician's N	ame (First, M.I., Last)	Company City, State, Zi	Phone Number		
		7	13,16		
Signature of Alcohol Technician		Date Mor	th 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		
_			Zate Month Maj 1081		
Form DOT F 1380 (Rev. 5/	2008)		OMB No. 2105-0529		

Intoximeters ASU XL

Test Number: 215 Serial Number: 11421 Test Date: 07/13/2016 Test Time: 09:13:42 Test Temperature: 22,3°C

Test Type: Screening Reason for Test: Random

Test Statum: Puccess

Tape

Print Additional Results Here or Affix With Tamper Evident Tape

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER