

(OTG)

COLLECTION INFORMATION FORM

[Complete this form and send to collection site along with custody and control (COC) form]

PLACE THIS ACCOUNT NUMBER ON THE CCF.....**OTG**

Donor Name _____ SS# _____

_____ **Urine Drug Collection Required** _____ **Breath Alcohol Test Required**

Observed Collection _____ Yes _____ No

Employee Transported to Collection Site _____ Yes _____ No

Name of Supervisor Transporting Employee _____ Title of Supervisor _____

Sent to Collection Site Date _____ Time _____

Expected Arrival Time at Collection Site _____

(If donor does not arrive by this time, please call the person requesting the test.)

Date & Time of Arrival _____ Date _____ Time _____

Date & Time of Test _____ Date _____ Time _____

Collection Site Name _____

Collection Site Address _____

Name of Supervisor Requesting Test _____

Title _____ Phone Number _____

Verbal Result _____ Date _____ Time _____ Status _____

- TYPE OF TEST:**
- Pre-employment
 - Random
 - Reasonable Cause
 - Post Accident
 - Follow-up
 - Return to Duty
 - Other

- TYPE OF CUSTODY AND CONTROL FORM TO BE USED:**
- Federal DOT Custody and Control Form
 - NON Regulated Non DOT Custody and Control Form

BILLING INFORMATION:

Please Bill All Collection Charges to:

TMHC Services, Inc.
2121 SW Chelsea Drive
Topeka, Kansas 66614
(785) 291-9123

Please Mail or Fax Breath Alcohol Test Results to:

TMHC Services, Inc.
2121 SW Chelsea Drive
Topeka, Kansas 66614
(785) 291-9123 OR fax to 785-232-5016