

Claim Number:

## Concentra Medical Centers (MD)

8101 Pulaski Hwy Suite H Baltimore, MD 21237  
Phone: (410) 687-6462 Fax: (410) 687-2261

Service Date: 10/26/2022

### Non-Injury Work Status Report

**Patient:** Brice, Kenyon J.

**SSN:** XXXXX6056

**Address:** 234 Crocker Dr  
BEL AIR, MD 21014

**Home:** (410) 831-5378

**Work:** Ext.:

**Employer Location:** Roy Salmon Trucking

**Address:** 9737 Eustice Rd  
Randallstown, MD 2113325

**Auth. by:**

**Contact:** Roy Salmon

**Role:** Primary Contact

**Phone:** (443) 629-4648 **Ext.:**

**Fax:** (443) 299-6806

#### This Visit:

**Time In:** 01:20 pm

**Time Out:** 02:04 pm

**Visit Type:** New

#### ***Reg UDS & BAT PrePI***

Breath Alcohol Test PrePlacement

Regulated UDS PrePlacement 65304

#### Result Status:

Job description was provided by employer and reviewed by examining provider  
May work without limitations/restrictions

**Remarks:**

## 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 Kenyon Bruce  
(Print) (First, M.I., Last)

B: SSN or Employee ID No. B-620-465-398-002

C: Employer Name Roy Salmon Trucking  
Street 9737 Eustice Rd,  
Randallstown, MD 21133

City, State, ZIP  
DER Name and Telephone No. Roy Salmon (443) 629-4648  
DER Name DER (Area Code & 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 U.S. Department of Transportation regulations and that the identifying information provided on the form is true and correct.

X [Signature] X 10 22 21  
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 U.S. Department of Transportation regulations, 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
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CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form.

REMARKS:

Alcohol Technician's Company T. KISTO Company Street Address Concentra  
8101 Pulaski Hwy, Suite H  
Baltimore, MD 21237  
Phone: 410-687-6462  
Fax: 410-687-2261

(PRINT) Alcohol Technician's Name (First, M.I., Last) [Signature] Company City, State, Zip  
Phone Number (Area Code & Number) 10/26/22

Signature of Alcohol Technician 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

TAMPER

Intoximeters: ASV XL

Test Number: 6732

Serial Number: 10641

Test Date: 10/26/2022

Test Time: 14:00:18

Test Temperature: 24.3°C

Test Type: Screening

Reason for Test:

Pre-Employment

Type	g/210L	Time
BLNK	0.000	14:00:28
SUBJ	0.000	14:00:47

Test Status: Success

EVIDENT



## FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7922075070



OMB No. 0930-0158

## STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

<b>A. Employer Name, Address, I.D. No.</b> Concentra Downtown BALTIMORE Roy Salmon Trucking - 2818-22749 9737 Eustice Rd Randallstown, MD 21133 Phone: 443-628-4648 Fax: 443-299-6806		<b>Lab Acct #:</b> 65018890	<b>B. MRO Name, Address, Phone and Fax No.</b> Michelle Alexander, M.D. 8140 Ward Parkway Kansas City, MO 64114 Phone: 888-382-2281 Fax: 913-469-4029
<b>C. Doctor, SEN, npi, cell, or DEL State and ID:</b> 344154		<b>D. Specimen Testing Method:</b> <input type="checkbox"/> FCS <input type="checkbox"/> FSC Specify DOT Agency: <input checked="" type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG	
<b>E. Reason for Test:</b> <input checked="" type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow Up <input type="checkbox"/> Other (Specify)			
<b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (Specify)			
<b>G. Collection Site Address:</b> Concentra Downtown BALTIMORE - 2822 100 S CHARLES ST STE 150 BALTIMORE, MD 21201		<b>Collector Contact Info:</b> Phone 410-752-3010 Fax 410-539-7023 Other	

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID	
<b>Collection:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark	
<b>URINE:</b> Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. Enter Remark <input type="checkbox"/> Observed, Enter Remark	
<b>ORAL FLUID:</b> Split type <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided Each Device Within Expiration Date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volume Indicator(s) Observed	
<b>REMARKS:</b>	

## STEP 3: Collector affixes seal(s) to bottle(s)/tube(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

## SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

<b>X</b> Signature of Collector Xavier Davis (PRINT) Collector's Name (First, MI, Last)	Date (Mo./Day/Yr.) 09 / 20 / 2022	Time of Collection 5:30:26 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	Name of Delivery Service FEDEX
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## 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 label affixed to each specimen bottle is correct:

<b>X</b> Signature of Donor: Erick Rhodes (PRINT) Donor's Name (First, MI, Last)	Date (Mo./Day/Yr.) 09 / 20 / 2022
Email Day Phone (252) 370-3557 Evening Phone ( ) Not Provided	Date of Birth 01 / 21 / 1964 Date (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

<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID	
In accordance with applicable Federal requirements, my verification is:	
<input type="checkbox"/> Negative <input type="checkbox"/> Positive for:	
<input type="checkbox"/> Dilute	
<input type="checkbox"/> Refusal to Test because - check reason(s) below:	
<input type="checkbox"/> ADULTERATED (adulterant/reason):	
<input type="checkbox"/> SUBSTITUTED	
<input type="checkbox"/> OTHER:	
<b>REMARKS:</b>	
<b>X</b> 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:	
<input type="checkbox"/> RECONFIRMED for:	
<input type="checkbox"/> FAILED TO RECONFIRM for:	
<b>REMARKS:</b>	
<b>X</b> Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)