



F A X

TO
 Name Hugh Date 10 / 19 / 2015
 Company CMG/ESG Phone #
 Department/Location Fax # 507 . 216 . 4904

FROM
 Name
 Company Olmsted Medical Center Phone # 507 . 292 . 7186
 Department/Location Occupational Medicine Fax # 507 . 292 . 7001

- As we discussed
- As you requested
- For your information
- Original will follow via mail
- Please process
- URGENT

Total number of pages
 (Including cover page)
 3

Comments:

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GOOD HEALTH STARTS WITH GREAT CARE.™

ATTENTION:

Hugh Fendry
CMG
3707 Commercial Dr SW
Rochester, MN 55902

Company: CMG (CMGESG)
Participant: Kimath Kong
Participant ID: 146
SSN: 525-55-8779

Results of Controlled Substance Test

Test Type: Post-accident Test
Record Status: **Negative**
Collection Date/Time: 10/16/2015 1835
Batch ID: 20151019
Specimen ID: PP409756
Collection Site: Olmsted Medical Center
210 9Th Street SE
Rochester, MN 55904
Laboratory: Medtox Laboratories
402 W Cty Rd D
St. Paul, MN 55112
Date COC Received: 10/19/2015
Sample Type: Urine

<u>Substance Tested</u>	<u>Result</u>
Amphetamines	Negative
Cocaine	Negative
Opiates	Negative
Phencyclidine	Negative
Marijuana	Negative

Adulterant/validity testing performed on this specimen.

Alcohol Testing Form

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

OMC
ROCHESTER MN
CMI, Inc.
Intoxilyzer 240
Serial Number: 1025680

Type of Test:
Non-DOT Screening
Reason for Test:
Post Accident
Test Number: 0105
Date: 10/16/2015

Operator ID#: 42648
Operator Name:
KRISTA L
CORSON
Subject Company:
REICHEL FOODS CMG
Subject ID#: 52558779
Subject Name:
KIMATH
KONG

Sequence	Result	Time
Diagnostics	PASS	18:33
Test# 0105	.000	18:33

Test Is Negative

• STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name Kimath Kong
(Print) (First, M.I., Last)

B: SSN or Employee ID No. 525-55-8779

C: Employer Name Reichel Foods - CMG
 Street 3707 Commercial Dr. SW
 City, State, Zip Rochester, MN 55902

DER Name and Telephone No. Kelsy Sinkink 507 923 4955
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 and that the identifying information provided on the form is true and correct.

[Signature] 10 10 15
 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 and that I am qualified to operate the testing device(s) identifying 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 #	QR Lot # & Exp Date	Activation Time	Reading Time	Result
105						

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

REMARKS:

OMC-Hospital 1650 4th St SE
 Alcohol Technician's Company Company Street Address
Krista L. Corson Rochester, MN 507 529 6100
(PRINT) Alcohol Technician's Name (First, M.I., Last) Company City, State, Zip Phone Number

[Signature] 10 16 2015
 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

Print
Additional Results Here
or Affix With
Tampar Evident Tape

