

# TEST RESULTS RECORD

Test Reference Number MD-S6101 Name of Collector \_\_\_\_\_

## COMPANY INFORMATION

Company Name Corporate Management Group Phone 651-666-3883 Fax \_\_\_\_\_  
 Address 400 Broadway Ave City St. Paul Park State/Province MN Zip/Postal Code 55071

## DONOR INFORMATION

Last Name \_\_\_\_\_ Employee I.D. \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Type of Identification Provided:  Driver's License  Employee Photo I.D.  Other \_\_\_\_\_  
 Reason for test:  Pre-employment  Random  Reasonable cause  Post-accident  Other \_\_\_\_\_

## CERTIFICATION

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and alcohol.

Donor signature Teng Chang Date / Time 10/18/2018

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge.

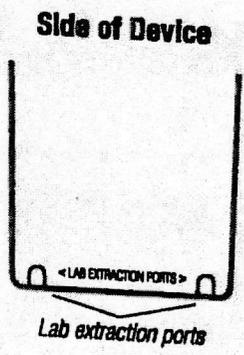
Collector signature [Signature] Date / Time 10/18/18

Laboratory signature \_\_\_\_\_ Date / Time received \_\_\_\_\_

## TEST RESULTS

Date/Time Collected \_\_\_\_\_  
 Time Interpreted \_\_\_\_\_

NOTE: Lab personnel obtain specimen samples by puncturing the lab extraction ports on the side of device with a needle and syringe and drawing out the sample.



Drug Name	Symbol	Negative	Positive	Not tested
<del>Alcohol</del>	<del>ALC</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input checked="" type="checkbox"/></del>
<del>Buprenorphine</del>	<del>BUP</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>Cocaine</del>	<del>COC</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>Marijuana</del>	<del>THC</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>Methamphetamine</del>	<del>MET</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>Oxycodone</del>	<del>OXY</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>
<del>[Other]</del>	<del>[Symbol]</del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>	<del><input type="checkbox"/></del>

Notes / Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_