an NDMC to enrollees upon denial, in whole or in part, of an enrollee's coverage request. This denial may be subject to a series of administrative review levels, involving defined steps and timeframes. The NDMC was developed to ensure Medicare enrollees have access to information needed to navigate the Medicare beneficiary appeals process. The NDMC meets requirements for both Medicare's standard and expedited appeals processes.

Medicare health plans provide an NDP to enrollees upon denial, in whole or in part, of payment for a service or item that the enrollee received. This denial may be subject to a series of administrative review levels, involving defined steps and timeframes. The NDP was developed to ensure Medicare enrollees have access to information needed to navigate the Medicare beneficiary appeals process. The NDP meets requirements for Medicare's standard appeals process. Form Number: CMS-10003 (OMB#: 0938-0829); Frequency: Yearly; Affected Public: Business or other for-profits and Not-for-profit institutions; Number of Respondents: 740; Total Annual Responses: 1,168,368; Total Annual *Hours:* 194,728. (For policy questions regarding this collection contact Stephanie Simons at 206-615-2420. For all other issues call 410–786–1326.)

3. Type of Information Collection *Request:* Extension of a currently approved collection; Title of Information Collection: Federal Qualification Application (42 CFR 417.140) and Medicare Health Care Prepayment Plan Application (42 CFR 417.800); Use: The application is the collection form used to obtain information to determine if an applicant meets the regulatory requirements to enter into a contract with CMS as a Federal Qualified health maintenance organization (HMO) or to provide health benefits to Medicare beneficiaries as a Medicare Health Care Prepayment Plan contractor. Form Number: CMS-901A & 901D (OMB#: 0938-0470); Frequency: Once; Affected Public: Business or other for-profits and Not-for-profit institutions; Number of Respondents: 20; Total Annual Responses: 20; Total Annual Hours: 800. (For policy questions regarding this collection

contact Heidi Arndt at 410–786–1607. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/ PaperworkReductionActof1995*, or email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786– 1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on *August 16, 2010.*

OMB, Office of Information and Regulatory Affairs, *Attention:* CMS Desk Officer, *Fax Number:* (202) 395– 6974, *E-mail: OIRA_submission* @omb.eop.gov.

Dated: July 9, 2010.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2010–17181 Filed 7–15–10; 8:45 am] BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project: Mandatory Guidelines for Federal Workplace Drug Testing Programs (OMB No. 0930–0158)— Revision

SAMHSA's Mandatory Guidelines for Federal Workplace Drug Testing Programs will request OMB approval for the Federal Drug Testing Custody and Control Form for Federal agency and federally regulated drug testing programs which must comply with the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs (73 FR 71858) dated November 25, 2008, and for the information provided by laboratories for the National Laboratory Certification Program (NLCP).

The Federal Drug Testing Custody and Control Form (Federal CCF) is used by all Federal agencies and employers regulated by the Department of Transportation to document the collection and chain of custody of urine specimens at the collection site, for laboratories to report results, and for Medical Review Officers to make a determination. The current Federal CCF approved by OMB has a November 30, 2011 expiration date. SAMHSA has resubmitted the Federal CCF with revisions to the form for OMB approval.

• The first change is to add a new item in Step 1 of Copy 1, which lists the acronyms for the Federal testing authorities under which the specimen is collected. The new Step 1 (d) would read as follows: "D. Specify Testing Authority: HHS, NRC, DOT—Specify DOT Agency: FMCSA, FAA, FRA, FTA, PHMSA, USCG" with a checkbox beside each agency name.

• The second change is to revise the Federal CCF Copy 1 to permit use by Instrumented Initial Test Facility (IITF), in addition to laboratories.

• The third change is to add the new drug analytes required by the revised Guidelines to the Primary Specimen Report section in Step 5(a) on Copy 1. The new drug analytes are methylenedioxymethamphetamine (MDMA), commonly known as "ecstasy"; methyleneamphetamine (MDA), and

methylenedioxyethylamphetamine (MDEA). MDA and MDEA are both close chemical analogues of MDMA.

• The fourth change is to revise the Medical Review Officer (MRO) reporting sections on Copy 2 for primary specimens (Step 6) and for split specimens (Step 7) to facilitate reporting in accordance with the Guidelines.

Below is a copy of the revised Federal CCF:

BILLING CODE 4162-20-P

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



| SPEC | CIMEN ID NO. 00000 | 01 | | | | |
|--|---|---|---|------------------------------------|-----------------------|---------------|
| TEP 1: COMPLETED BY COLLECTOR OR E | MPLOYER REPRESENTATIVE | | ACCESSIC | NN NO. | | |
| L Employer Name, Address, I.D. No. | | B. MRO Name, Addre | iss, Phone No. and F | ax No. | | |
| C. Donor SSN or Employee I.D. No D. Specify Testing Authority HHS NR E. Reason for Test: Pre-employment Rendo F. Drug Tests to be Performed: THC, CO G. Collection Site Address: | m 🔲 Reesonable Suspicion/Cause 🔲 | Post Accident | to Duty Follow-up r (specify) | Cther (specify) | | |
| | | Co | llector Phone No | | | |
| | | Co | Nector Fax No | | | |
| TEP 2: COMPLETED BY COLLECTOR (make | | | | | | |
| | No, Enter Remark Collection: |] Split 🔲 Single [| None Provided, Enter | Romank [| Observed, E | inter Aarnark |
| EMARKS | | | | | | |
| TEP 3: Collector affixes bottle seal(s) to bot TEP 4: CHAIN OF CUSTODY - INITIATED BY contrly that the specimen given b me by the donor Netced labeled scaled and released b the Delivery | COLLECTOR AND CONPLETED identified in the contilication section on | BY TEST FACILITY Copy 2 of this form was | SPECINI | EP 5 on Copy EN BOTTLE(S) RE | • | ••• |
| morand, manenda, solanda ann tomanoda ar bhe channoty : F | легтале плави из аналиатын мин аррила | une r'equerce requirermanta. | r | | | |
| LSign | ature of Collector | AM | | | | |
| (PRINT) Collector's Hame First, M. Last | Date MoDer/Yrt | Phi Time of Collection | | | | |
| ECEIVED AT LAB OR ITTE: | | I may of Collection | Primary Specimen | Name of Delivery Se SPECIMEN BC | | FASED TO- |
| <u> </u> | | | Bottle Seal Inlact | | | |
| Signat | ure of Accessioner | | YES NO | | | |
| PRINT) Accessioner's Nam | - (Pi 149 (| Date (Mo.Day/Yr) | If NO, Enter remark in Step 5A. | | | |
| TEP 5A: PRIMARY SPECIMEN REPORT - CO | | Date (moverale st) | ві знір зи. | L | | |
| INEGATIVE DILUTE | Marijuana Metabolite (Δ9-T Coceine Metabolite (B2 PCP LTERATED SUBSTITUTE | E) Morp | isine 🗌 🗍 🖉 | amphetamine Imphetamine | | |
| | | | | | | |
| Facility (if different from above) : certify that the specimen identified on this form was ever | | custody procedures, analy | zed, and reported in acco | ordance with applic | abio Federal <i>i</i> | oquiromonts. |
| Signature of Cartifying Technician/Sci | entist (PIBA | T) Certifying Technician/Sc | ientist's Name (First, M, L | .a¢l) | bate (Mo | Day/Yr) |
| TEP 55: COMPLETED BY SPLIT TESTING L | ABORATORY | | | | | |
| | | RECONFIRM - REASON | 1 | | | |
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| Laboratory Neme | I certify that the split specimen identified and reported in accordance with applicable | | и цран төсөфа, непалона с | ising creation case | ooy processine | a, anazzana |
| Laboratory Name | | e Federal requirements. | u span nacepa, nananou u Centilying Boientist's Name | | Date (Mo./ | Ĺ |

| 0000001 SPECIMEN ID NO. | PLACE OVER CAP | 0000001 SPECIMEN BOTTLE SEAL | Date (Mc/Dey/Yr) |
|--|----------------------|------------------------------------|-------------------------------------|
| B 00000001 (SPLIT) SPECIMEN ID NO. | PLACE OVER CAP | 0000001 SPECIMEN BOTTLE SEAL | Dete (McDey/Yr) Donor's kritials |

COPY 1 - TEST FACILITY COPY

Back of Copy 1 - 4

Public Burden Statement

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0158. Public reporting burden for this collection of information is estimated to average 5 minutes/donor, 4 minutes/collector, 3 minutes/test facility, and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland 20857.

| A Employee Name, Address, LD No. B MBO Name, Address, Phone No. and Fex No. A Employee Name, Address, LD No. B MBO Name, Address, Phone No. and Fex No. C. Donor SSN or Employee ID, No. B MBO Name, Address, Phone No. and Fex No. D Specify Tealing Authority. HKS MKG DOT - Specify DOT Agency: FMCSA FAA FAA FAA FAA DMKGA USCG B. Reason for Teal: HKS MKG MKG DOT - Specify DOT Agency: FMCSA DAT FAA FAA DMKGA USCG B. Reason for Teal: HKC, COC, PCR, OP, AMP THC & COC ON Other (specify) Collector Phone No. Collector Phone No. C. Obecton Site Address: Collector Phone No. Collector Phone No. Collector Phone No. S. Collector Site Address: Collector Phone No. Collector Phone No. Collector Phone No. STEP 2: COMPLETED BY COLLECTOR (malio remarks when appropriate) Collector reads specify more transmit within A minutes. Ware Marked State State Dother seal(a) to bother(s); Collector Address eat(a). Donor completes STEP 5 on Copy 2 (MRO Copy) STEP 3: Collector affires bother seal(a) collector Address eat(a). Donor completes STEP 5 on Copy 2 (MRO Copy) STEP 4: Collector fittine bother seal(a) to bother(s); Collector Address eat(a) collector Address eat(a) collector eat(a) collector eat(a) collector. STEP 3: Collector fittine bother seal(a) to bother(s); Collector Address eat(a) collector eat(a) collector. STEP 4: Collector fittine bother seat(a) to bother(s); Collector fit i haw or deat(a) collect | SPECIMEN ID NO. | 0000001 | |
|---|--|--|--|
| C. Donor JSN or Employee I.Q. No. S. Specify Testing Authority: H-S. Colored Safety of Testing Authority: H-S. Colored Safety Of Agency: The Action to Testing Testing and the state of the Action appropriate Safety Of Agency: Colored Fax No. Colored FAX N | | | DN NO. |
| 0. Specify Treating Authority: | A. Employer Name, Address, I.D. No. | B. MRO Name, Address, Phone No. and F | ax No. |
| E. Galactor IN/Tatt: Pre-applyment Findom Passonable SupplexitorConse Peak Acklerk Collector Pace No. Collector Attrace No. Collector No. Collector Attrace No. | C. Donor SSN or Employee I.D. No. | | |
| E Orug Tiests to be Performed: | | | |
| G. Colector Phone No | | | [] Conne (of menh) |
| Collector Fax No. TEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector made applimm temperature within a minutes. Termentane butters and the remarks when appropriate) Collector made applimm temperature within a minutes. Termentane butters and the temperature within a minutes. Termentane butters and the temperature within a minutes. Termentane butters and the butters and the butter formatic. Set a Collector attrace botter seal(s) to botter (content of the content of the content of the butter formatic. Set a Collector attrace botter seal(s) to botter (content of the content of the applicable formatic regulationanes. Set a Collector attrace botter seal(s) to botter (content of the content of the content of the applicable formatic regulationanes. Set a Collector attrace botter seal(s) to botter (content of the content of the applicable formatic regulationanes. Set a Collector attrace and released to the Delayery Sender of the accordance of the applicable formatic regulationanes. Set a Collector attrace and released to the Delayery Sender of the term of the applicable formatic regulationanes. Set a Collector attrace and released to the Delayery Sender of the term of the applicable formatic regulationanes. Set a Collector attrace and released to the Delayery Sender of the term of the applicable formatic regulation at the information provided on the term of the applicable formatic regulation at the information provided on the term of the applicable formatic regulation at the information provided on the term of addiented of a new names; each specimen botte is correct. X Set Set a Collector reactive the termentanes of the content addiented of the approvementation of the soft of a specime of the information provided on the term of the addiented of the approvementation of the soft of the appro | G. Collection Site Address: | | |
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| TEP 4: CHAIN OF CUSTOV - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY Tothy that is prevenen give to ma by the done instrahlid on the conflication section on Cony? of this form wes collected, believed, sealed and released to the Delivery Service nobel in accordance with applicable Fadaral negulations and on the table attent of the specimen identification section of Cony? of the FORM ATCE DE SYDERE SYD | Remarks | K Collection: Split Strigle None Provided, Enter | Hemark Ubserved, Enter Hemark |
| X Signature of Colocity AW (PNRH) Collector's News (First, M, Lan) Des (MoDiry/n) The of Collection STEP 5: COMPLETED BY DONOR The of Collector's News (First, M, Lan) Des (MoDiry/n) Torotty that i provided my urbs specimen is the Collector, theil have not additerated it in any manner, each specimen both uses seeled with a tamper-evident seel in my memory, and that the information provided on this form and on the labol allow to each specimen both is a correct. X Signature of Deriver Version (PNRT) Donor's Neme (First, M, Lan) Daytime Phone No Date of Birth(Note: provided my manner) and the specimen identified by this form, hershe may contact you to eask about prescriptions and corr the specimen identified by this form, hershe may contact you to eask about prescriptions and cover the-countor medications by your own necords. THIS LIST IS NOT NECESSARY to on choose the to see of the provided my origin as provided my may have taken. Therefore, you may ward to make a list of these medications for your own necords. THIS LIST IS NOT NECESSARY to on choose the to see of the provide of paper or con the back of your corp (Corp 5) DO NOT PROVIDE THIS INFORMATION ON THE BLOCK OFFICER - PRIMARY SPECIMEN INFORMATION ON THE BLOCK OFFICER - SPLIT SPECIMEN Integer (PRIMARY SPECIMEN ALL ADDD) Integer Provided and the application of the split specimen first wards and the split specimen first wards a | STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR I certify that the specimen given to me by the donor identified in the | AND COMPLETED BY TEST FACILITY the certification section on Copy 2 of this form was collected, | |
| PRIMIP Collector's lawse (Plat, III, Last) Mere et Bainey Service The of Collector The of Collect | aneed, some and research to the convery cervice react in according to the converse sector and the converse sector according to the c | а налко тап арранацио гонов и нединотиятся. | |
| PRINT Clastedra Name (Part, M. Lan) Des (MaDayrin) The at Collection Name of Deterministics Provided my urble spectration to the collector; the II have not adultistated if in any manner, each spectration bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label afficed to each spectram bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label afficed to each spectram bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label afficed to each spectram bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label afficed to be ach spectram bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label afficed to be ach spectram bottle used was seeled with a tamper-evident secure X X Buptone of Converting the test results for the spectram identified by this form, herishe may contact you to ask topout proscriptione and over the-counter modications you may have taken. Therefore, you may want to make a list of these medications for your conv records. THIS ULST IS NOT NECESSARY if you choose to make a list, do so either on a apparate piece of paper or on the back of your copy (Copy 5). – DO NOT PROVIDE THIS NECESSARY if you choose to make a list of these medications for your conv records. THIS ULST IS NOT STEP 8: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN A accordance with applicable Federal requirements, my verification is: NEGATIVE POSITIVE tor: Desting POSI | Signature | | 1 |
| STEP 5: COMPLETED BY DONOR Contribution to provide on white specimen is the collector; that if have not adultizated if in any mamor; each specimen bottle used was seeled with a tamper-evident seel in my presence; and that the information provided on this form and on the label alticed to each specimen bottle is correct. X | (PRINT) Collector's Name (First, M. Last) | | |
| my presence; and that the information provided on this form and on the label alficed to each specimen bother is corned. Segmitive et Donor (PIRIT) Donor * Neme (First, Mi, List) Date of Birth | STEP 5: COMPLETED BY DONOR | | |
| Daytime Phone No. [| x | | Date (Mo/Der//ri |
| After the Medical Review Officer receives the test results for the spocimen identified by this form, he/she may contact you to ask about proscriptions 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 INCESSARY, if you choose to make a list, do so so ether 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 & COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN is according with applicable Federal requirements, my verification is: NEGATIVEPOSITIVE for; | - | | Date of Birth / |
| h accordance with applicable Federal requirements, my verification is: DILUTE NEGATIVE POSITIVE for: SUBSTITUTED SUBSTITUTED OTHER: REMARKS: X Signature of Madical Review Officer (PRINT) Madical Review Officer's Name (Final, Mi, Last) Signature of Madical Review Officer (PRINT) Madical Review Officer's Name (Final, Mi, Last) Date (MoDe/YT) Accordance with applicable Federal requirements, my verification for the split spectmen (if tested) is: FAILED TO RECONFIRM for: REMARKS: X X X X X X X X X X X X X | over-the-counter medications you may have taken. Therefi NECESSARY. If you choose to make a list, do so either or INFORMATION ON THE BACK OF ANY OTHER COPY C | ore, you may want to make a list of those medications for y n a separate piece of paper or on the back of your copy (DF THE FORM, TAKE COPY 5 WITH YOU. | t you to ask about prescriptions and our own records. THIS LIST IS NOT |
| NEGATIVE POSITIVE for: | | | |
| | | | |
| SUBSTITUTED OTHER: SUBSTITUTED OTHER: AREMARKS: X Signature of Medical Review Officer SPLIT SPECIMEN in accordance with applicable Federal requirements, my verification for the split specimen (# tested) is RECONFIRMED for: FAILED TO RECONFIRM for: REMARKS: X | REFUSAL TO TEST because - check reason(s) below: | 0. | TEST CANCELLED |
| AEMARKS: | SUBSTITUTED | | |
| STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is: | REMARKS: | | |
| STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is: | | · · · · · · · · · · · · · · · · · · · | |
| STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is: | Χ | | |
| In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is: | Signature of Medical Review Officer STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SP | (PRINT) Medical Review Officer's Name (First, MI, Lae PLIT SPECIMEN |) Data (Mo/Day/Yr) |
| □ FAILED TO RECONFIRM for: | | | ······································ |
| REMARKS: | RECONFIRMED for: | D | TEST CANCELLED |
| X , (| FAILED TO RECONFIRM for: | | |
| X Signature of Medical Review Officer (PRIMT) Medical Review Officer's Name /First, ML Lawn, Date Adv Datavity | REMARKS: | | |
| X // Signature of Medical Review Officer (PRINT) Medical Review Officer's Name /First, Ms. Lasth Date (Michael Science) | | | TERMINAL PROPERTY AND A DESCRIPTION OF THE DESCRIPT |
| | Signature of Medical Review Officer | (Pfill(T) Medical Review Officer's Name (Elect 1st 1 - | Date (Mo/Day/Yr) |

COPY 2 - MEDICAL REVIEW OFFICER COPY

| SPECIMEN ID NO. | 0000001 | | |
|--|--|--|-----------------------------------|
| STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPR | ESENTATIVE | ACCESSIC | DN NO. |
| A. Employer Name, Address, I.D. No. | | e, Address, Phone No. and F | 'ax No. |
| C. Donor SSN or Employee I.D. No. D. Specify Testing Authority: HHS NRC DCT – E. Reason for Test: Pre-employment Random Reasonable S F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMF G. Collection Site Address: | uspicion/Cause 🗌 Post Accident | | FTA PHMSA USCG Other (specify) |
| | | Collector Phone No. | |
| | | Collector Fax No. | |
| STEP 2 COMPLETED BY COLLECTOR (make remarks when | | | |
| Temperature between \$0° and 100° F? 🗌 Yes 🛄 No, Enter Remark | Collection: Split 🗌 1 | iingle 🗌 None Provided, Enter | Pemark 🔲 Observed, Enter Remark |
| REMARKS | | | |
| STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector | datas assi/a). Donor initiala : | aal/a) Dapar somelates 67 | ED 5 on Come 2 (UBO Come) |
| STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR A | ND COMPLETED BY TEST F/ | callity | EP 5 on Copy 2 (MHC Copy) |
| I certify that the specimen given to me by the donor identified in the o labeled, sealed and released to the Delivery Service noted in accord | pertification section on Copy 2 of | this form was collected, | SPECIMEN BOTTLE(S) RELEASED TO: |
| X Signature of C | onector | | |
| | 1 1 | PN | 1 |
| (PRINT) Collector's Name (First, MI, Last) | Date (MccDayY) | Time of Collection | Hame of Delivery Service |
| STEP 5: COMPLETED BY DONOR I certify that I provided my urine specimen to the collector; that I have | a most and addition makened it im more another | | |
| my presence; and that the information provided on this form and on t | he label affixed to each specime | n bottle is correct. | |
| A Signature of Donor | (PRINT) Do | vor's Name (First, MI, Lasi) | Date (Mo/Dey/Yr) |
| Daytime Phone No. () Ex | ening Phone No. () | | Date of Birth / / |
| After the Medical Review Officer receives the test results for over-the-counter medications you may have taken. Therefore NECESSARY. If you choose to make a list, do so either on a INFORMATION ON THE BACK OF ANY OTHER COPY OF | , you may want to make a lis separate piece of paper or | t of those medications for y on the back of your copy (| our own records. THIS LIST IS NOT |
| STEP & COMPLETED BY MEDICAL REVIEW OFFICER - PRIM | | · · · · · · · · · · · · · · · · · · · | |
| In accordance with applicable Federal requirements, my verification | 5. | | |
| NEGATIVE OSITIVE for: | | | |
| | | | |
| REFUSAL TO TEST because – check reason(s) below: ADULTERATED (adultorant/reason): SUBSTITUTED OTHER; | | | TEST CANCELLED |
| REMARKS: | | | |
| | | | |
| Y | | | |
| Signature of Madicsi Review Officer | (PRINT) Modical I | www.omcer's Name (First, ML, Las | 0 Date (Mo/Day/Yr) |
| STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLI | | | |
| In accordance with applicable Federal requirements, my ventication | lor the split specimen (if lested) | S. | |
| RECONFIRMED for: | | 0 | TEST CANCELLED |
| FAILED TO RECONFIRM for: | | | |
| REMARKS: | | | |
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| | , | | |
| X Stonature of Medical Review Officer | | awlew Officer's Name (First, MI, Las | Date (Mo/Daw/Yr) |
| SHERE AND A A A A A A A A A A A A A A A A A A | (PPURE) (MHERCALF | warmen vermer a radistik (* 1931, aff, 1.38 | V DATE (MONDAWYT) |

COPY 3 - COLLECTOR COPY

| | SPECIMEN ID NO. | 0000001 | | |
|--|---|--|--|--|
| TEP 1: COMPLETED BY COLLECTO | | SENTATIVE | ACCESSION | NO. |
| 4. Employer Name, Address, I.D. No. | | B, MRO Name, Ad | dress, Phone No. and Fa | x No. |
| C. Donor SSN or Employee I.D. No D. Specify Testing Authority: HHS E. Reason for Test: Pre-employment | | Specify DOT Agency: 📄 FMCSA | | |
| | THC, COC, PCP, OPI, AMP | | ther (specify) | |
| | | | Collector Phone No | |
| | | | Collector Fax No. | |
| STEP 2: COMPLETED BY COLLECTO Temperature between 90° and 100° F? | | ppropriate) Collector reads speci Collector: Split Single | men temperature within | |
| REMARKS | | | | |
| STEP 3: Collector affixes bottle seal(<u>STEP 4: CHAIN OF CUSTODY - INITIA</u> <i>I certify that the specimen given to me by</i> labeled, sealed and released to the Deliv | TED BY COLLECTOR ANI | D COMPLETED BY TEST FACILIT inflication section on Copy 2 of this t | Y Imm was collected | SPECIMEN BOTTLE(S) RELEASED TO: |
| X | Signature of Col | Nector | AM | |
| (Phile 1) Collector's | Name (First, MI, Last) | Date (No/DeyYn | PM Time of Collection | Name of Delivery Service |
| X Signature of Oorie | | (PRINT) Donor's He | rne (First, M, Last) | |
| Daytime Phone No. () | Ever | ning Phone No. () | D | ate of Birth (Mc/Dav/7r) |
| After the Medical Review Officer rec over-the-counter medications you m NECESSARY, If you choose to make INFORMATION ON THE BACK OF STEP 6: COMPLETED BY MEDICAL F | ay have taken. Therefore, e a list, do so either on a s ANY OTHER COPY OF T REVIEW OFFICER - PRIMA | you may want to make a list of th separate piece of paper or on th HE FORM. TAKE COPY 5 WITH ARY SPECIMEN | ose medications for you e back of your copy (Ce | you to ask about prescriptions and ur own records. THIS LIST IS NOT |
| In accordance with applicable Federal re- | · · · | : | | |
| OILUTE OILUTE REFUSAL TO TEST because – cher ADULTERATED (adulterant) | ck reason(s) below: | | | EST CANCELLED |
| | | | | |
| REMARKS: | | | | |
| Signature of Medical Re | | (PRNT) Modical Asyles | Officer's Name (First, Mi, Last) | Data (MoDay/Yr) |
| STEP 7: COMPLETED BY MEDICAL I In accordance with applicable Federal ne | | | | |
| | | | | EST CANCELLED |
| FAILED TO RECONFIRM for: _ REMARKS: | | | 041104149990000000000000000000000000000 | |
| | | | | |
| X Signature of Medical Ro | wiew Officer | (PRINT) Medical Review | Officer's Name (First, M. Last) | Date (Mc/Day/Yr) |
| | | | | |

COPY 4 - EMPLOYER COPY

| | 0000001 | | |
|--|--|--|--|
| STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRE | SENTATIVE | ACCESSI | ON NO. |
| A. Employer Name, Address, I.D. No. | B.MRO Name | , Address, Phone No. and | Fax No. |
| E. Reason for Test: Pre-employment Random Reasonable Su | spicion/Cause Post Accident | Return to Duty EFollow-up | FTA PHMSA USCG Other (specify) |
| F. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP G. Collection Site Address: | THC & COC Only |] Other (specify) | именинан он то то то <u>то и и и и и и и и и и и и и и и и и и и</u> |
| | | Collector Phone No | |
| | | Collector Fax No. | |
| STEP 2: COMPLETED BY COLLECTOR (make remarks when a Temperature between 90° and 100° F? 🔛 Yes 🗔 No, Enter Remark | Collection: Split Si | | |
| REMARKS | and the second | | |
| | | | |
| STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector da STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AN | | | TEP 5 on Copy 2 (MRO Copy) |
| l certify that the specimen given to me by the donor identified in the ce labeled, sealed and released to the Delivery Service noted in accorda. | artification section on Copy 2 of # | his form was collected, | SPECIMEN BOTTLE(S) RELEASED TO: |
| X Signature of Col | lector | Al | - |
| - | | PI | м |
| (PRINT) Collector's Name (First, Mi, Last) STEP 5: COMPLETED BY DONOR | Date (Mo/DayYr) | Time of Collection | Name of Delivery Service |
| X Signature of Ocner | | e & Manne (First, SM, Last) | Dete (No/Day/Yr) |
| Daytime Phone No. () Ever After the Medical Review Officer receives the test results for th over-the-counter medications you may have taken. Therefore, NECESSARY, if you choose to make a list, do so either on a t NFORMATION ON THE BACK OF ANY OTHER COPY OF T | you may want to make a list soparate piece of paper or o | form, he/she may conta of those medications for in the back of your copy | your own records. THIS LIST IS NOT |
| STEP & COMPLETED BY MEDICAL REVIEW OFFICER - PRIMA | | | |
| In accordance with applicable Federal requirements, my verification is: | : | | |
| NEGATIVE POSITIVE for: DILUTE | | | |
| REFUSAL TO TEST because - check reason(s) below: | | | TEST CANCELLED |
| ADULTERATED (adultorant/reason): SUBSTITUTED OTHER: | | | |
| SUBSTITUTED | | | |
| SUBSTITUTED | | | i 1 |
| SUBSTITUTED OTHER: | (PRINT) Medical Re SPECIMEN | riov Officer's Name (First, 58, Las | n) Date (Mc/Day/Yr) |
| SUBSTITUTED OTHER: SIgnature of Medical Review Officer Step 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT In accordance with applicable Federal requirements, my verification for | (PRINT) Medical Re SPECIMEN | riow Officer's Name (First, 58, Las | in) |
| | (PRINT) Medical Re- SPECIMEN The split spectmen (if tested) is: | riow Officer's Name (First, 58, Las | |
| SUBSTITUTED OTHER: OTHER: Signature of Medical Review Officer STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT In accordance with applicable Federal requirements, my verification fo RECONFIRMED for: | (PRINT) Medical Re SPECIMEN If the split specimen (if lested) is: | riow Officer's Name (First, 58, Las | |
| SUBSTITUTED OTHER: OTHER: REMARKS: Signature of Medical Review Officer STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT In accordance with applicable Federal requirements, my verification fo RECONFIRMED for: FAILED TO RECONFIRM for: | (PRINT) Medical Re SPECIMEN If the split specimen (if lested) is: | riow Officer's Name (First, 58, Las | |

COPY 5 - DONOR COPY

Back of Copy 5

Instructions for Completing the Federal Drug Testing Custody and Control Form

When making entries use black or blue ink pen and press firmly

Collector ensures that the name and address of the HHS-certified Instrumented Initial Test Facility (IITF) or HHS-certified laboratory are on the top of the Federal CCF and the Specimen identification (I.D.) number on the top of the Federal CCF matches the Specimen I.D. number on the label(s)/seal(s).

STEP 1:

- Collector ensures that the required information is in STEP 1. Collector enters a remark in STEP 2 if Donor refuses to provide his/her SSN or Employee I.D. number.
- Collector gives collection container to Donor and instructs Donor to provide a specimen. Collector notes any unusual behavior or appearance of Donor in the remarks line STEP 2. If the Donor's conduct at any time during the collection process clearly indicates an attempt to tamper with the specimen, Collector notes the conduct in the remarks line in STEP 2 and takes action as required.

STEP 2:

- Collector checks specimen temperature within 4 minutes after receiving the specimen from Donor and marks the appropriate temperature box in STEP 2. If the temperature is outside the acceptable range, Collector enters a remark in STEP 2 and takes action as required.
- Collector inspects the specimen and notes any unusual findings in the remarks line in STEP 2 and takes action as required. Any specimen with unusual physical characteristics (e.g., unusual color, presence of foreign objects or material, unusual odor) cannot be sent to an IITF and must be sent to an HHS-certified laboratory for testing, as required.
- Collector determines the volume of specimen in the collection container. If the volume is acceptable, Collector proceeds with the collection. If the volume is less than required by the Federal Agency, Collector takes action as required and enters remarks in STEP 2. If no specimen is collected by the end of the collection process, Collector checks the *None Provided* box, enters a remark in STEP 2, discards Copy 1, and distributes remaining copies as required.
- Collector checks the Split or Single specimen collection box. If the collection is observed, Collector checks the Observed box and enters a remark in STEP 2.

STEP 3:

- Donor watches Collector pour the specimen from the collection container into the specimen bottle(s), place the cap(s) on the specimen bottle(s), and affix the label(s)/seal(s) on the specimen bottle(s).
- Collector dates the specimen bottle label(s) after placement on the specimen bottle(s).
- Donor initials the specimen bottle label(s) after placement on the specimen bottle(s).
- Collector turns to Copy 2 (Medical Review Officer Copy) and instructs the Donor to read and complete the certification statement in STEP 5 (signature, printed name, date, phone numbers, and date of birth). If Donor refuses to sign the certification statement, Collector enters a remark in STEP 2 on Copy 1.

STEP 4:

 Collector completes STEP 4 on Copy 1 (signature, printed name, date, time of collection, and name of delivery service), places the sealed specimen bottle(s) and Copy 1 in a leak-proof plastic bag, seals the bag, prepares the specimen package for shipment, and distributes the remaining CCF copies as required.

Privacy Act Statement: (For Federal Employees Only)

Submission of the requested information on the attached form is voluntary. However, incomplete submission of the requested information, refusal to provide a urine specimen, or substitution or adulteration of a specimen may result in delay or denial of your application for employment/appointment or may result in removal from the Federal service or other disciplinary action.

The authority for obtaining the urine specimen and identifying information contained herein is Executive Order 12564 ("Drug-Free Federal Workplace"), 5 U.S.C. Sec. 3301 (2), 5 U.S.C. Sec. 7301, and Section 503 of Public Law 100-71, 5 U.S.C. Sec. 7301 note. Under provisions of Executive Order 12564 and 5 U.S.C. 7301, test results may only be disclosed to agency officials on a need-to-know basis. This may include the agency Medical Review Officer, the administrator of the Employee Assistance Program, and a supervisor with authority to take adverse personnel action. This information may also be disclosed to a court where necessary to defend against a challenge to an adverse personnel action.

Submission of your SSN is not required by law and is voluntary. Your refusal to furnish your number will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited, pursuant to Executive Order 9397, for purposes of associating information in agency files relating to you and for purposes of identifying the urine specimen provided for testing for the presence of illegal drugs. If you refuse to indicate your SSN, a substitute number or other

identifier will be assigned, as required, to process the specimen.

Public Burden Statement

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0158. Public reporting burden for this collection of information is estimated to average 5 minutes/donor, 4 minutes/collector, 3 minutes/test facility; and 3 minutes/Medical Review Officer. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland 20857.

BILLING CODE 4162-20-C

Prior to an inspection, a laboratory is required to submit specific information regarding its laboratory procedures. Collecting this information prior to an inspection allows the inspectors to thoroughly review and understand the laboratory's testing procedures before arriving at the laboratory.

The annual total burden estimates for the Federal Drug Testing Custody and

Control Form, the NLCP application, the NLCP inspection checklist, and NLCP recordkeeping requirements are shown in the following table.

| Form/respondent | Burden/ response (hrs.) | Number of responses | Total annual burden (hrs.) |
|---------------------------------|-------------------------------|---------------------|----------------------------------|
| Custody and Control Form: | | | |
| Donor | .08 | 7,096,000 | 567,680 |
| Collector | .07 | 7,096,000 | 496,720 |
| Laboratory | .05 | 7,096,000 | 354,800 |
| Medical Review Officer | .05 | 7,096,000 | 354,800 |
| Laboratory Application | 3.00 | 3 | 9 |
| Laboratory Inspection Checklist | 3.00 | 100 | 300 |
| Laboratory Recordkeeping | 250.00 | 50 | 12,500 |
| Total | | | 1,786,809 |

Written comments and recommendations concerning the proposed information collection should be sent by August 16, 2010 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 12, 2010.

Dennis O. Romero,

Deputy Director, Office of Program Services. [FR Doc. 2010–17400 Filed 7–15–10; 8:45 am]

BILLING CODE 4162-20-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project: Pretesting of Substance Abuse Prevention and Treatment and Mental Health Services Communication Messages—(OMB No. 0930–0196)— Extension

As the Federal agency responsible for developing and disseminating authoritative knowledge about substance abuse prevention, addiction treatment, and mental health services and for mobilizing consumer support and increasing public understanding to overcome the stigma attached to addiction and mental illness, the Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for development and dissemination of a wide range of education and information materials for