FRIENDS MEDICAL LABORATORY, Inc.
Southwestern Professional Building
5820 Southwestern Blvd.
Baltimore, MD 21227-4404
410-247-4417
Fax: 410-247-4426
Toll Free: 800-875-4797

COLLECTION SITE: _____

Custody & Request Form

A. NAME: _____ SS # – –

Day Phone: – – Night Phone: – –

B. COLLECTION TYPE: ☐ Clinical ☐ Employment C. FRIENDS' ACCT. NO.:

D. REASON FOR TESTING:
☐ Pre-Employment ☐ Clinical 1st Time ☐ Clinical Follow-UP
☐ Return to Duty ☐ Random ☐ Periodic ☐ Reasonable Cause ☐ Post Accident
☐ Follow-Up ☐ Other (specify) _____

E. REQUESTING AGENCY/EMPLOYER:
Address: _____

Phone: – – Fax: – –

F. TESTS REQUESTED (please check):
☐ NIDA 5 PANEL ☐ FORENSIC 9 PANEL ☐ BREATH ALCOHOL (BAT)
☐ FULL SCREEN ☐ URINE ALCOHOL ☐ OTHER (specify) _____

G. SPECIMEN TEMPERATURE WITHIN RANGE: ☐ Yes ☐ No
Comments:

H. COLLECTOR'S CERTIFICATION: (I certify that the specimen identified on this form is the specimen presented to me by the donor, that it bears the same identity as on the bottle label, and where requested, is the same specimen observed by me.)
SUPERVISED ☐ Yes ☐ No

(collector's printed name) _____ (collector's signature) _____ (date) _____ (time) _____

I. CHAIN OF CUSTODY:

DATE	SPECIMEN RELEASED BY	SPECIMEN RECEIVED BY	PURPOSE OF CHANGE
/ /	*		PROVIDE SPECIMEN
/ /			
/ /			
/ /			

* *By signing this form I acknowledge the specimen that is labeled with this request form to be mine and that the collector has labeled & sealed the specimen in my presence. If collection was witnessed, that I release from liability any and all persons associated with witnessing collection, and authorize FML to test for drugs of abuse and to report results to the above requestor. I certify the specimen is my own.*

J. DONOR'S MEDICATIONS (please list any within last 7 days): _____

Please be assured that this information will be kept confidential, at the laboratory, and will not be released to the employer. Upon reviewing the results of your lab test, an inquiry may be necessary concerning prescriptions and over-the-counter medications that you may have taken recently. Your above phone number will be used to contact you if necessary. I certify that the above information is correct to my knowledge and if necessary, I can produce the product and/or prescription for the medications as mentioned.

PRINT NAME _____ SIGNATURE _____ INITIALS _____ DATE _____