

August 9, 2024

Dr. Kirk Roberts, MD/MRO
2600 Grand Ave., Suite 500
Kansas City, MO 64108

"SPLIT-SAMPLE" Test Request Form

Dear Dr. Roberts & Laboratory Directors:

I would like to have my original specimen re-tested using the split-sample provided (Bottle B). I understand that my cost of conducting this "Split-Sample" will be \$395.00, payable to Forensic Drug Testing Services, and prior to services. If this is a D.O.T. regulated test, my employer will pay for such tests. I understand that my employer may decline the testing of my "Split-Sample", if my request was made 72 or more hours after my MRO confirmed positive test result. I understand that I will **NOT** be allowed to continue working for the Company, while awaiting the results of this "Split-Sample". Results generally take 15-20 business days to get back from the alternate lab. The results of the "Split Sample" are final. The following information will be helpful in identifying my original sample:

DONOR:	<input type="text"/>	Date & Time of Collection:	<input type="text"/>
EMPLOYER:	<input type="text"/>	Specimen ID:	<input type="text"/>
Request Date:	<input type="text"/>	GC/MS L.O.D. for:	<input type="text"/>

Original Testing Lab:	<input type="text" value="CRL, 8433 Quivira Road, Lenexa, KS (913)492-3652"/>
MRO Information:	<input type="text" value="SAME AS ABOVE"/>
Bottle 'B' Split Lab:	<input type="text" value="LabCorp, Inc., 1904 Alexander Drive, R.T.P., N.C. 27709 (800) 833-3984 (Bill Acct: 893337)"/>

DONOR'S AUTHORIZATION

I, the above listed Donor, am requesting that the "Original Testing Lab", listed above, securely package and ship my sample to the "Bottle B Split Lab", listed above for GC/MS testing, for the substance(s) found in my original sample. The results of this test shall be reported directly to Forensic Drug Testing Services, Inc. and my employer. I understand that I must pre-pay for these services, direct to Forensic Drug Testing. Financial assistance may be available from your employer. I hereby authorize a \$395 charge to my Credit Card for "B bottle" GC/MS testing.

[PAYMENT INFORMATION](#) (To be pre-paid by the requesting Employee/Employer.

* **NO REFUNDS or cancellations permitted.**



CARD Number:	<input type="text"/>	Exp:	<input type="text"/>
Cardholder's Name:	<input type="text"/>	Code:	<input type="text"/>

CARDHOLDER/DONOR's Authorization Signature

Date & Time signed

EMPLOYER'S Representative (Print Name Agent)

Employee's Printed Name (Employee)

EMPLOYER'S Signature

Date

Signature (Employee)

Date

☐ Please Invoice our FORENSIC DTS Account.