Clear Form

FORENSIC
DRUG TESTING SERVICES, INC

73700 Dinah Shore Drive, Suite B206, Palm Desert, CA 92211-0815
612 South J Street, Suite 8, Imperial, CA 92251
760-770-6068

Directed to:

Dr. Jerome Cooper, MD/MRO
772 North Broad Street
Mooresville, NC 28115

SPLIT-SAMPLE TEST REQUEST FORM

Dear Dr. Cooper & 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 as directed by the below listed employer.* I understand that my employer may decline the testing of my "*Split-Sample*", if my request was made 72 or more hours after my results verification conversation with the above listed MRO. 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 secondary lab. The results of the "*Split Sample*" are final and may not be challenged by either party. The following information will required in identifying my original sample:

DONOR:		**Bottle A & B Collection Date:**	
Request Date:		**Bottle A & B Collection Time:**	
Original Testing Lab:		**Chain of Custody #:**	
MRO Information:		**Specimen ID:**	
Bottle 'B' Testing Lab:		**Bottle B Confirm Testing for:**	

DONOR'S AUTHORIZATION FOR BOTTLE 'B' SPLIT-SAMPLE TESTING

I, *the above listed Donor*, am requesting that the "Original Testing Lab", listed above, securely package and ship my sample to the "Bottle B Testing Lab", listed above for GC/MS confirmatory 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., the MRO and the original employer listed upon the CCF.

Requesting Donor's Signature	Time Signed	Date Signed
Approving Employer Signature	Time Approved	Date Approved

ONCE SIGNED, PLEASE SEND TO FORENSIC DTS AT: *Info@fdtsi.com* **or fax:** *(760) 770-0806*

PRE-PAYMENT REQUIRED - *Please indicate responsible Party Paying for Testing*

☐ **EMPLOYER** *(Please Invoice Me)*
☐ **DONOR** (I will pay online at www.fdtsi.com)
☐ **EMPLOYER** *(I will pay at www.fdtsi.com now)*
☐ **DONOR** *(I will be paying cash at FORENSIC DTS Office)*

I understand that I must pre-pay for these services, as directed above. I hereby authorize a $395.00 charge to my account, as shown above. I fully understand, once payment is made, there are
NO REFUNDS, CANCELATIONS, ACCOUNT ADJUSTMENTS OR ACCOUNT CREDITS PERMITTED

PAYMENT Approval Signature: _____ **Date:** _____

Printed Name: _____ **E-Mail:** _____