



**STANISLAUS COUNTY  
ORDERED FOR CAUSE DRUG/ALCOHOL TEST  
EMPLOYEE CLINIC PASSPORT**

**\*This form is to be used for all employees, except DOT employees.  
DOT employees, please use the DOT passport only.**

<http://intranet/resources/safety-manual/safety-manual-files/DOT%20ONLY%20Employee%20Clinic%20Passport.pdf/view?searchterm=dot>

You, (employee name) \_\_\_\_\_ are hereby ordered by (Name of Department Head and/or his/her designee) \_\_\_\_\_ to participate in a For Cause drug/alcohol test pursuant to Stanislaus County Ordinance 3.08.050. This order has been given under the authority of the Chief Executive Officer. You must be provided with a copy of this Passport prior to being transported to the testing facility.

Date \_\_\_\_\_ Time \_\_\_\_\_

**Employee Information**

Social Security Number (Last six digits only) \_\_\_\_\_

Photo ID Number \_\_\_\_\_ ID Type \_\_\_\_\_

<p><b>CONCENTRA</b> 1524 McHenry Ave., Suite 135 Modesto, CA 95350 (209) 575-5801 / M-F 9:00 a.m.-5:00 p.m. Breath Alcohol Testing: Yes <b>You must arrive by 4:45 p.m. for a urine drug/alcohol test.</b></p>	<p><b>CONCENTRA</b> 1340 Mitchell Rd. Modesto, CA 95350 (209) 581-9711 / M-F 9:00 a.m.-5:00 p.m. Breath Alcohol Testing: Yes <b>You must arrive by 4:45 p.m. for a urine drug/alcohol test.</b></p>
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**COLLECTION / LAB SITE INSTRUCTIONS**

Attach this sheet to the Custody Control Form to be sent to the Medical Review Officer.  
Refer County inquiries to the Chief Executive Office/Human Resources at 209-525-6333.  
Submit results by fax to 209-544-6226.

**AFTER HOURS (AFTER 5:00 P.M.) AND WEEKEND INSTRUCTIONS**  
Contact Alere Toxicology 1-877-292-1822 – Select Option 2

The answering service will request additional information (see next page) and will have an after-hours coordinator contact you to coordinate the collection. If the coordinator is unable to identify a collection site in the area that is available to conduct the collection, they will be able to coordinate an on-site collection.

**TAKE ENTIRE PACKET WITH YOU TO TESTING FACILITY**



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**Testing Information**

For Cause       Return to Work       Follow-up

**Type**

Drug       Breath Alcohol       Both required For Cause

**Sample Results**

Clear       Refused to comply       Breath Alcohol

Sent to DHHS Certified Laboratory       Second sample collected and sent to lab

**Manager/Supervisor Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Manager/Supervisor Department \_\_\_\_\_ Job Title \_\_\_\_\_

**If the test is positive or inconclusive, you are automatically on Paid Administrative Leave pursuant to Stanislaus County Ordinance 3.28.090 and the approval of the Chief Executive Officer. You will need to provide your supervisor/manager with a direct contact number(s) to be reached while on paid administrative leave. At any time, the County may require you to return to work.**

Print Name of Manager/Supervisor \_\_\_\_\_

Signature of Manager/Supervisor \_\_\_\_\_

Date \_\_\_\_\_

cc: Employee

## STANISLAUS COUNTY FOR CAUSE REASONABLE SUSPICION DRUG AND ALCOHOL TESTING - BRIEF INSTRUCTIONS

Whenever a supervisor observes independently, or is advised by another employee about, an employee who may be under the influence of drugs/alcohol, the supervisor should **immediately** contact the appropriate management staff and implement procedures listed below. Do not proceed without specific directions. Below is a summary of the procedures found in the **County's Human Resource Guide Tab 8, ORDERED FOR CAUSE DRUG/ ALCOHOL TESTING**. The For Cause Drug Testing Procedures can be found on the County's Intranet at <http://intranet/departments/hr/human-resource-forms> and comply with the County Drug Free Workplace Policy and should be strictly followed. **DOT employees DO NOT** use this procedure; contact CEO-HR and RMD.

1. Have employee escorted to a private area and do not leave unattended!
2. Suspicion unsubstantiated—employee may return to work
3. If the employee is probationary or extra help, contact the Chief Executive Office Human Resource staff.
4. Complete observation section on Reasonable Suspicion Checklist—give a copy to the employee.
5. Tell employee there are concerns regarding his/her behavior.
6. Inform employee of representation rights before questioning.
7. Notify Union of possible For Cause Drug Test.
8. If employee does waive representation, document it.
9. Employee can be questioned using the prepared questions found at the end of the Reasonable Suspicion Checklist after arrival of union rep or after waiving rights to representation.
10. If union rep does not arrive within 90 minutes, do not question.
11. Failure to cooperate and/or leaving the facility are considered insubordination and are causes for discipline.
12. Inform the employee that law enforcement will be notified if he/she attempts to drive.
13. Suspicion substantiated—testing should start at the testing facility within two hours of suspicion. Do not delay if representation is not present.
14. Obtain verbal authorization to test the employee from the Department Head or CEO/HR Manager. Proceed to order the employee to the medical examination.
15. Daytime Scheduling Hotline: 209-575-5801 (US Health Works McHenry) or 209-581-9711 (US Health Works Mitchell Rd.) Follow instructions on the For Cause Passport.
16. After Hours Scheduling: 1-877-292-1822 (Alere Toxicology). Use information provided on the For Cause Passport.
17. Complete For Cause Passport and give a copy to the employee prior to transporting.
18. Transport employee to the testing facility.
19. Document everything!

**AFTER HOURS – QUESTIONS FROM COORDINATOR / ADDITIONAL INSTRUCTIONS**

Question from Coordinator	Your Response:
1 Company Name	Caller must identify themselves as a CSAC-EIA Customer and then provide the company name - Stanislaus County
2 Testing ID	Testing ID – Non-DOT - 5546 28301
3 Is caller the Designated Employer Representative (Human Resource or Risk Manager) or Supervisor	HR Manager / Risk Management <input type="checkbox"/> Supervisor <input type="checkbox"/>
4 Designated Employer Representative (Risk Management) /Supervisor Name and Phone Number	_____ Your name and phone Number
5 Address	_____ Work Location Address
6 Donor info – Name, SSN/ID number, Phone Number	_____ Employee Name _____ Employee ID number Phone #
7 Type services needed Urine collection and/or Breath Alcohol	Non DOT - Urine and Breath Alcohol <input type="checkbox"/>
8 Do you have an Alere Lab Chain of Custody form?	Departments that operate 7 days a week or 24 hours a day have a supply of forms – Check with your HR Unit. <i>If collection site is DNT Health Check - 400 12<sup>th</sup> St, Ste 23, Modesto – they have the Alere Lab Chain of Custody forms. A copy of the form is attached to this document and may be used if needed.</i>
9. Panel Account Number	For all Non DOT employees, the panel account number is 631. <i>Be sure to mark Panel #631 on the Chain of Custody form as this tells the collection facility and lab what drugs to screen on and what the County’s cut off levels are.</i>

1345709/1078569



1111 Newton St., Gretna, LA 70053  
450 Southlake Blvd., Richmond, VA 23236  
Phone: 800.433.3823 | Fax: 504.361.8298

Airbill / Courier Tracking Number



Specimen ID 202455589

STEP 1: TO BE COMPLETED by Collector or Employer/Client Representative

A. Employer/Client Name, Address, Phone, & Fax:

STANISLAUS COUNTY/NON DOT FOR  
1020 10TH ST SUITE 5100  
ROBERTO, CA 95854  
909-545-5725 909-545-5779

Facility Number

554628301

B. MRO Name, Address, Phone, & Fax:

HEINEN, BRIAN D  
261 LEON AVE  
MUNICIPAL LA 70001  
(800) 457-0435 504-361-8298

C. Name/ID:

PRINT ALL IN CAPS for Donor Name (Last Name, First Name MI); leave space between names/ID/Auxiliary Data.

Sub Acct: (optional)

D. Donor SSN or Employee ID No.:

Donor SSN or Employee ID No. field

E. Daytime Phone No.:

F. Evening Phone No.:

G. Reason for Test:  Pre-Employment  Random  Reasonable Suspicion/Cause  Post Accident  Return to Duty  Follow-up  Other

H. Panel: If a panel is not selected below, Alere will use the default for the Facility listed above. See back of copy 4 for additional panel instructions.

A Primary Panel  B  C  D  E  Other: (write in panel number)

I. Collection Site Name & Address: Collector Phone No.:

(Enter here if not printed below)

TO BE COMPLETED BY COLLECTOR

Collector Phone No. field

Collector Number

60161

STEP 2: TO BE COMPLETED by Collector - Within 4 minutes, read temperature of specimen.

Within range?  Yes 90°-100°F / 32°-38°C  No  Below 90°F / 32°C  Above 100°F / 38°C

Oral Fluid, temperature  not applicable

Split Specimen  No  Yes

Observed

Remarks:

STEP 3: TO BE COMPLETED by Collector and Donor - Collector affixes bottle seals(s) to bottle(s). Collector dates seal(s). Donor initials seal(s).

STEP 4: TO BE COMPLETED by Donor

I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen container used was sealed with tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen container is correct.

X Signature of Donor Date: / /

Donor Date of Birth (Mo./Day/Yr.) / /

STEP 5: CHAIN OF CUSTODY - Initiated by Collector and completed by Laboratory

I certify that the specimen given to me by the donor identified above was collected, labeled, sealed, and released in accordance with applicable requirements.

Collector Name field

PRINT Collector Name (First, MI, Last)

Date Collected field

Date Collected (Mo./Day/Yr.)

Time Collected: AM PM

Specimen Bottle(s) Released to: COURIER

Service Transferring Specimen to Lab

STEP 6: TO BE COMPLETED by Lab

RECEIVED AT LAB:

X Signature of Accessioner PRINT Accessioner Name (First MI Last)

Date (Mo/Dy/Yr) Primary Specimen Seal Intact?  Yes  No, Enter Remark

Specimen(s) Released to: TEMPORARY STORAGE

LAB NUMBER

Remarks:



SPECIMEN ID NO. 202455589

A



Date (Mo./Day/Yr.)

202455589

SPECIMEN BOTTLE SEAL

Donor's Initials

SEAL



SPECIMEN ID NO. 202455589

B (SPLIT)



Date (Mo./Day/Yr.)

202455589

SPECIMEN BOTTLE SEAL

Donor's Initials

SEAL



**STANISLAUS COUNTY  
ORDERED DRUG/ALCOHOL TEST  
SPECIFIC DRUGS OR METABOLITE CUT-OFF LIMIT**

<b>DRUG</b>	<b>SCREENING METHOD</b>	<b>CUT – OFF (ng/mL)</b>	<b>CONFIRMATION METHOD</b>	<b>CUT – OFF (ng/mL)</b>
<b>AMPHETAMINES</b>	OnLine	1000	GC/MS	500
<b>COCAINE</b>	OnLine	300	GC/MS*	150
<b>CANNABINOIDS</b>	OnLine	50	GC/MS**	15
<b>OPIATES</b> (including synthetics)	OnLine	300	GC/MS	300
<b>PCP</b>	OnLine	25	GC/MS	25
<b>BARBITURATES</b> (including synthetics)	OnLine	300	GC/MS	300
<b>BENZODIAZEPINES</b>	OnLine	300	GC/MS	300
<b>METHADONE</b>	OnLine	300	GC/MS	300
<b>PROPOXYPHENE</b>	OnLine	300	GC/MS	300

If a specific drug is present at or above the GC/MS cut-off level, the GC/MS test shall be considered a positive test confirming the positive screen. The quantitative concentration limits described herein are measured in nanograms (millionths of a gram, abbreviated "ng") of substance per milliliter (abbreviated "ml") of urine.

**Retest: If any amount of the above-mentioned drugs is present at the retest, the retest will be considered positive.**

All drugs in the drug families listed above will be included in the testing.