DMV

DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OREGON 97314

REPORT OF POSITIVE DRUG TEST

UNDER ORS 825.410 AND CHAPTER 163, OREGON LAWS 2013

Fill in name of Motor Carrier OR School Transportation Provider:

NAME OF MOTOR CARRIER	NAME OF SCHOOL TRANSPORTATION PROVIDER	
SPECIMEN ID NUMBER	DATE OF DRUG TEST	
NAME OF INDIVIDUAL TESTED	LAST FOUR DIGITS OF SSN **XXX - XX -**	DATE OF BIRTH

PART 1 – CERTIFICATION OF MEDICAL REVIEW OFFICER

(A COPY OF THE FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM, COPY 2, MUST BE ATTACHED)

By signing below I, the Medical Review Officer, certify the following:

1. I am the medical review officer for the drug testing program or consortium of the motor carrier or school transportation provider listed above.
2. I am a licensed physician with knowledge of substance abuse disorders.
3. I have correctly followed the drug testing required by 49 CFR Part 382 that are applicable to the Medical Review Officer as follows:
   - ☐ I reviewed the chain of custody of the specimen submitted by the individual tested to ensure that it is complete and sufficient on its face;
   - ☐ I examined any alternate medical explanations for the positive drug test result;
   - ☐ I gave the individual tested an opportunity to discuss the test result prior to making a final decision to verify the positive test result as follows:
     - ☐ I talked directly with the individual tested before verifying the test as positive; or
     - ☐ After making all reasonable efforts to contact the individual tested, including contacting a designated management official of the motor carrier or school transportation provider, I was unable to communicate directly with the individual within 10 days of the date I received the test result from the laboratory; or
     - ☐ The individual tested was instructed by the designated management official of the motor carrier or school transportation provider to contact me and the individual then failed to contact me within 72 hours; or
     - ☐ The individual tested expressly declined an opportunity to discuss the test result.
   - ☐ (TEST RESULT FOR OPIATES ONLY – GC/MS CONFIRMATION DOES NOT CONFIRM THE PRESENCE OF 6-MONOACETYLMORPHINE) I determined that there is clinical evidence, in addition to the urine test, of unauthorized use of an opium, opiate or opium derivative or the level is 15,000 ng/ml or above.
4. By submitting this report and a copy of the Federal Drug Testing, Custody and Control Form, Copy 2 attached, I verify a positive drug test result from the individual tested.

I further certify that I have reviewed my records and that the information contained in Part 1 of this report is true and correct to the best of my knowledge.

PRINTED NAME	SIGNATURE **X**

ADDRESS	CITY	STATE	ZIP CODE

PART 2 – CERTIFICATION OF MOTOR CARRIER or SCHOOL TRANSPORTATION PROVIDER

(FILL IN NAME OF MOTOR CARRIER **or** SCHOOL TRANSPORTATION PROVIDER)

NAME OF MOTOR CARRIER	NAME OF SCHOOL TRANSPORTATION PROVIDER

BY SIGNING BELOW, I CERTIFY THE FOLLOWING:

1. The motor carrier or school transportation provider listed above:
   - ☐ Has an in-house drug and alcohol testing program that meets the federal requirements of 49 C.F.R. part 382; or
   - ☐ Is a member of a consortium, as defined in 49 C.F.R. 382.107, that provides drug and alcohol testing that meets the federal requirements of 49 C.F.R. part 382.

     NAME OF CONSORTIUM: _____
2. The individual tested is subject to drug testing by the Motor Carrier or School Transportation Provider.

I further certify that I have reviewed the records and the information contained in this report is true and correct to the best of my knowledge.

PRINTED NAME OF DESIGNATED MOTOR CARRIER REPRESENTATIVE OR SCHOOL TRANSPORTATION PROVIDER			
ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE OF DESIGNATED MOTOR CARRIER REPRESENTATIVE OR SCHOOL TRANSPORTATION PROVIDER **X**	DATE