Alere Toxicology Services, Inc.

SPECIMEN ID NO. 7934136574

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

Abbott

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

LAB NUMBER

O M B No. 0930- 0158

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address I.D. No.

INKLINE INC - 139290-1206
113 FAIRFIELD WAY
BLOOMINGDALE, IL 60108
Phone: 331-302-4429

DER Name & Phone #: GEDIMINAS MICKEVICIUS, DALILA SANCHEZ

Lab Acct #: Z1392901206

B. MRO Name, Address, Phone No. and Fax No.
Dr. Brian N. Heinen
151 Leon Ave
Eunice, LA 70535
Phone: 888-382-2281
Fax: 913-752-3148

C. Donor SSN, Employee I.D., or CDL State and No. TX24969809

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☑ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☑ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

F. Drug Tests to be Performed: ☑ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify)

G. Collection Site Address:
Concentra Downtown Houston - 2614
3695 Gulf Freeway Suite A
HOUSTON, TX 77003

2614
Clinic ID

Collector Contact Info: Phone 713-223-0838
Fax 713-223-1310
Other

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☑ URINE ☐ ORAL FLUID

COLLECTION	☑ Split	☐ Single	☐ None Provided, Enter Remark					
URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F?	☑ Yes	☐ No, Enter Remark	☐ Observed, Enter Remark					
ORAL FLUID: Split Type:	☐ Serial	☐ Concurrent	☐ Subdivided	Each Device Within Expiration Date?	☐ Yes	☐ No	☐ Volume Indicator(s) Observed	
REMARKS:								

STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.

X _____ Signature of Collector

Keisha Guillen Luna — (PRINT) Collector's Name (First, MI, Last)

07 / 28 / 2025 — Date (Mo/Day/Yr)

11:13:45 — Time of Collection ☑ AM ☐ PM

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

ALERE — Name of Delivery Service

STEP 5: COMPLETED BY DONOR

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

X _____ Signature of Donor

JAMES LEE CLARK III — (PRINT) Donor's Name (First, MI, Last)

07 / 28 / 2025 — Date (Mo/Day/Yr)

Email _____ Day Phone (662) 577-6463 Evening Phone ( ) Not Provided Date of Birth 05 / 07 / 1984 — Date (Mo/Day/Yr)

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). - DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN ☑ URINE ☐ ORAL FLUID

In accordance with applicable Federal requirements, my verification is:

☐ **Negative** ☐ **Positive for :** _____
☐ Dilute
☐ **Refusal to Test** because - check reason(s) below: ☐ **TEST CANCELLED**
☐ ADULTERATED (adulterant/reason): _____
☐ SUBSTITUTED
☐ OTHER _____

REMARKS: _____

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, MI, Last)

__/__/__ Date (Mo/Day/Yr)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:

☐ **RECONFIRMED for:** _____ ☐ **TEST CANCELLED**
☐ **FAILED TO RECONFIRM for:** _____

REMARKS: _____

X _____ Signature of Medical Review Officer

_____ (PRINT) Medical Review Officer's Name (First, MI, Last)

__/__/__ Date (Mo/Day/Yr)

Testing Conducted by Alere Toxicology Services, Inc.

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