INDIANA UNIVERSITY SOUTH BEND
HEALTH AND WELLNESS CENTER
Vera Z. Dwyer College of Health Sciences

Annual 11-Panel Drug Screen

Name: _____ Date of Birth: _____
University ID: _____

I, _____ hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites. If positive, there will be a blood draw immediately at the donor's expense, unless you have proof of medication via prescription.

Donor Signature: _____Date: _____

Program/Company: _____

Lot Number/Expiration Date: _____

I, the collector, certify that I collected the specimen provided by the donor and that is was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector's Signature: _____ Date: _____

Specimen Temperature: In range (90-100F) _____

Drug Name	+	-		+	-
Amphetamine (AMP)			Oxycodone (OXY		
Cocaine (COC)			Barbiturates (BAR)		
Marijuana (THC)			Benzodiazepine (BZD)		
Methamphetamine (mAMP)			Methadone (MTD)		
Ecstasy (MDMA)					
Opiates (OPI 2,000)					
Phencyclidine (PCP)					

Additional notes/prescriptions:

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