FORM 2083.1 (10/14) **STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION**

URINALYSIS PROCEDURE FORM

(To be used with Emit Drug Detection System)

INMATE'S NAME _____ DIN _____ TEST# _____

PRELIMINARY PROCEDURES

TIME URINE SPECIMENS REMOVED FROM THE REFRIGERATOR/FREEZER ___ ___ : ___ ___ AM - PM

TIME CALIBRATORS REMOVED FROM THE REFRIGERATOR/FREEZER ___ ___ : ___ ___ AM - PM

WAS TEMPERATURE OF ROOM WITHIN RANGE SUGGESTED BY MANUFACTURER YES ☐ NO ☐

REAGENT EXPIRATION DATE ___ ___ / ___ ___ / ___ ___ REAGENT LOT # _____

DAILY SET-UP

CHECK FLUID LEVELS ☐

CHECK ROTATOR BLANK RESULTS ☐

PRIME SYSTEM ☐

NEGATIVE CALIBRATOR/CONTROL EXPIRATION DATE ___ ___ / ___ ___ / ___ ___ LOT # _____

LOW CALIBRATION CONTROL ☐ N/A EXPIRATION DATE ___ ___ / ___ ___ / ___ ___ LOT # _____

CUTOFF CALIBRATOR RATE_____ EXPIRATION DATE ___ ___ / ___ ___ / ___ ___ LOT # _____

HIGH CALIBRATOR/CONTROL EXPIRATION DATE ___ ___ / ___ ___ / ___ ___ LOT # _____

WERE ADEQUATE SEPARATIONS ACHIEVED YES ☐ NO ☐

TEST

TIME OF TEST ___ ___ : ___ ___ AM - PM DATE OF TEST ___ ___ / ___ ___ / ___ ___

FINAL RESULT _____

OPERATORS NAME _____

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT, AND THAT I AM CERTIFIED ON THE EMIT DRUG DETECTION SYSTEM

_____ SIGNATURE

_____ DATE