STATE OF CALIFORNIA
DMV
Department of Motor Vehicles

Mail this form no later than five days after receiving notification of a positive result to:
Driver Safety Actions Unit
Attn: Special Certificate
2570 24th Street, MS J234
Sacramento, CA 95818-2526

POSITIVE CONTROLLED SUBSTANCE TEST RESULT REPORT

California Vehicle Code (CVC) §13376(b)(1) requires employers who provide pupil transportation, general public paratransit, or transportation of developmentally disabled persons to report to the Department of Motor Vehicles (DMV), any driver or applicant who fails to comply with the testing requirements for, or receives a positive test for a controlled substance. The employer, or rehabilitation, or return to duty program shall report any subsequent positive test result or drop from the program to DMV on a form approved by the department. According to CVC §13376(b)(3), the carrier that requested the test shall report the refusal, failure to comply, or positive test result to the department not later than five days after receiving notification of the test result on a form approved by the department.

This is the form approved by DMV for use to report such drivers or applicants.

Mail the original to the above address and submit a copy to your local California Highway Patrol Area Office, Attn: School Bus Officer/Coordinator.

Programs and testing must comply with the requirements specified in Part 382 (commencing with §382.101) of Title 49 of the *Code of Federal Regulations*

SECTION 1 — DRIVER INFORMATION (*Type or Print Legibly*)

DRIVER'S FULL NAME		BIRTHDATE	DRIVER LICENSE NUMBER
STREET ADDRESS	CITY	STATE ZIP CODE	TELEPHONE NUMBER ( )
CURRENT CERTIFICATE EXPIRATION DATE (*RENEWAL*)	CERTIFICATE APPLICATION DATE (*ORIGINAL*)		CERTIFICATE TYPE
AGENCY NAME ADMINISTERING TEST			TELEPHONE NUMBER ( )
AGENCY ADDRESS ADMINISTERING TEST	CITY		STATE ZIP CODE
REASON FOR TEST *(PRE-EMPLOYMENT, POST ACCIDENT, REASONABLE SUSPICION, RANDOM, RETURN TO DUTY, FOLLOW-UP)*		TEST DATE	TEST RESULTS/TEST REFUSED
EMPLOYER NAME (*PLEASE PRINT*)			EMPLOYERS TELEPHONE NUMBER ( )
EMPLOYER ADDRESS (*PLEASE* PRINT)	CITY		STATE ZIP CODE

SECTION 2 — REHABILITATION/RETURN TO DUTY PROGRAM INFORMATION (*For Existing Certificate Holders Only*)

REHABILITATION/RETURN TO DUTY PROGRAM NAME/ADDRESS	CITY	STATE ZIP CODE
PROGRAM LENGTH		PROGRAM START DATE
EMPLOYER IMPOSING PROGRAM PARTICIPATION (*PLEASE PRINT*)	CURRENT DATE	EMPLOYER'S TELEPHONE NUMBER ( )

SECTION 3 — POST PROGRAM DROPS

POSITIVE RESULTS SHOWN		DATE OF POSITIVE TEST RESULTS
REASON DRIVER DROPPED		DATE DRIVER DROPPED
NAME/AGENCY OF INDIVIDUAL REPORTING DROP INFORMATION	CURRENT DATE	TELEPHONE NUMBER ( )

I, the under signed, do hereby report the driver noted above as required according to CVC §13376(b)(1).

PERSON REPORTING APPLICANT/DRIVER (*PLEASE PRINT*)	SIGNATURE	DATE
	X	

Print Clear Form