#04-7984
P.C. 6400190

PRESIDENT'S DEPARTMENT
AIR LINE PILOTS ASSOCIATION, INTERNATIONAL
1625 MASSACHUSETTS AVENUE, N.W. ☐ WASHINGTON, DC 20036 ☐ 1-888-FLY-ALPA (1-888-359-2572)
FAX 202-797-4007

July 12, 2004

VIA FACSIMILE to 301-443-3031 and
E-MAIL to wvogl@samhsa.gov

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockwall II, Suite 815
Rockville, MD 20857

Re: FR Doc. 04-7984

Dear Sir or Madam:

These comments are submitted in response to the proposed revisions to the Mandatory Guidelines for Federal Workplace Drug Testing Programs, which include Point of Collection Testing, Instrumented Initial Testing Facilities, and alternative specimen collection. They are filed on behalf of the Air Line Pilots Association ("ALPA"), the principal union representing the nation's commercial pilots. ALPA represents more than 64,000 pilots at 42 airlines in the United States and Canada.

Point of Collection Testing

Point of Collection Testing ("POCT") as proposed, involves the use of both "instrumented" and "non-instrumented devices" that can be employed almost anywhere (not limited to a laboratory setting) and are expected to be operated by personnel who are not highly trained, in order to provide an immediate result on a screening test for drugs, or on a specimen validity test. HHS proposes to allow POCT of urine and oral fluids because such testing can provide quick negative drug and validity test results and thus reduce the use of more expensive testing equipment and personnel in a fixed facility.

While the agency proposes to authorize the use of such testing only for the initial tests, with any positive screen subject to confirmation testing in a laboratory, employers will undoubtedly promptly learn of any non-negative test results. Such tests are, of course, merely screening tests that cannot be counted on to produce an accurate or reliable non-negative result without a follow up confirmation test. The approach proposed raises serious concerns about the risks of false positive screening results stigmatizing innocent employees, or otherwise causing adverse effect to them.

Moreover, the very things that HHS identifies as advantages from POCT – performing the test outside a laboratory setting, using less expensive equipment and low level testers without much training – are the same factors that "make it very difficult, if not impossible to use a laboratory 'like' inspection and quality assurance process." 69 Fed. Reg. 19678 (Apr. 13, 2004). HHS, however, should not dispense with such procedural safeguards, for they are essential to the integrity of the program.

First, current collectors are not adequately educated to be trained as technicians. One of the weakest links in urine drug testing has always been the collector. These individuals are low paid, non-technical personnel with no forensic training, and they are often temporary workers. POCT requires the employer or its subcontractors to interpret results. If such testing is performed with "noninstrumented" devices, the technicians must correctly interpret color reactions, and assess whether the reaction has progressed appropriately. A technician's faulty interpretation or report would result in a false positive result. Technicians who use "instrumented" devices must also ensure that the devices are working properly, deal appropriately with a device reporting error messages, and be able to properly test, run and report negative, low and high controls. These tasks require technical expertise and judgment. Having less experienced personnel responsible for reporting initial test results, without supervision by highly trained laboratory personnel, greatly increases the likelihood of more erroneous reports. It also increases the risk of other kinds of problems that could cause misunderstanding and potential conflict between the collector and the employee.

Second, having such testing take place outside of a certified laboratory removes other important safeguards. The "Responsible Person" at a certified laboratory ensures that controls are proper, and makes corrections when necessary in accordance with scientific and forensic standards.

Third, the quality assurance proposed for POCT is much less protective than that which is presently required for the drug screening tests now required to be done in certified laboratories. The testing devices used for POCT drug testing would be subject to FDA clearance or approval, but the devices used for POCT specimen validity tests would not be subject to such FDA scrutiny. Moreover, while HHS proposes to "certify" the POCT devices, such certification falls far short of the current certification requirements laboratories must meet in order to perform screening and confirmation drug testing as well as validity testing. Laboratories "certified" by HHS must submit to periodic inspections, regular proficiency tests and blind specimen testing, among other things. POCT will not be inspected by HHS, nor will it be subject to proficiency or blind specimen testing. In our view, these are glaring shortcomings in this proposed form of testing.

Instrumented Initial Testing Facilities

HHS also proposes to allow screening tests to be done at Instrumented Initial Testing Facilities ("IITF"), laboratories that would be certified only to perform the screening portion of the testing process and not the confirmation testing. All non-negative samples would be required to be sent to a full service HHS certified laboratory for confirmation testing. IITFs would be subject to inspections and open and blind proficiency testing. However, unlike "full service" certified laboratories, HHS proposes to allow these facilities to operate without oversight by a "Responsible Person" with doctoral level credentials. The proposal to allow oversight of these facilities by a less qualified person than that allowed to supervise and oversee a full service laboratory is a flawed approach. The current requirement that certified laboratories have a "Responsible Person" at the helm, one with a specified level of education, training and experience, ensures that testing in the laboratory has appropriate quality control and quality assurance.

Requiring the initial tests and confirmation tests to be performed at the same laboratory location provides additional important protections in the testing process. For this reason, the recommendations pertaining to the earlier versions of the HHS Scientific Guidelines by the original scientific advisory board (the precursor to the current Drug Testing Advisory Board – "DTAB") and the consensus conference insisted that screening and confirmation be carried out at the same location. Currently, National Laboratory Certification Program ("NLCP") inspectors check to be sure that the certifying scientists in each laboratory routinely compare confirmation test results to screening test results for each specimen tested. This is a vital check on sample switching or aliquot confusion, and is a key safeguard in the oversight process.

HHS's proposal to have the technicians performing the initial drug tests overseen by a "Responsible Technician," instead of someone with the credentials of a "Responsible Person," is ill advised. The education and training required of a "Responsible Person" provides the knowledge and expertise necessary to properly carry out quality control and quality assurance oversight. For example, a "Responsible Person" would know the proper action to take when runs are out of control, whereas individuals lacking such credentials and expertise have been shown to lack such knowledge.

Having a screening test result reported separately prior to that test result being confirmed and validated also presents the risk that an employer will learn of unconfirmed non-negative results and stigmatize the employee. We have been told that screening test results have been leaked to employers in non-regulated workplace testing programs.

Any facility authorized to perform workplace drug or validity testing – that is testing whose consequences could be career-ending – should meet the standards currently required for HHS certified laboratories. Should HHS permit the use of IITFs, such

facilities should likewise be required to have a "Responsible Person" with the same qualifications as those required for full service HHS certified laboratories.

Elimination of Testing for PCP

Years of employee workplace drug testing has shown that PCP is not a drug for which testing is warranted. We urge HHS to review the available data, and to obtain input on this subject from experts in the industry, and to consider the significant cost savings that could be accomplished by eliminating this category of testing. We submit that employee testing for PCP is an unnecessary waste of resources and money.

Specimen Validity Testing

We have previously submitted comments stating our concerns about aspects of the specimen validity testing procedures. Our most recent comments are hereby incorporated by reference and are Attachment A hereto. Most importantly, a true confirmation test should be required before any result may be reported, regardless of whether the result reports the presence of an adulterant or an ultra-dilute (allegedly "substituted") urine sample. Such confirmation testing should involve testing of an independent aliquot using a second testing method other than that used for the screening test, one that is based on a different chemical or physical property of the analyte.

The proposed rules also would require validity testing for specimens that are collected under direct observation, such as oral fluids, hair and sweat patches. Validity testing, which has been fraught with problems and ruined the careers of innocent individuals, should not be included where there is no rationale for it. Clearly, where a sample is taken under direct observation an individual cannot have used a substitute without being detected. We urge HHS to eliminate validity testing where specimens are obtained under direct observation.

Alternative Specimens: Hair, Sweat and Oral Fluid

We oppose the inclusion of the proposed procedures for limited hair, sweat and oral fluid specimen testing. First, as HHS recognizes, none of these specimens could be used for all of the required types of testing. As such, introducing the use of additional specimens, performed under different protocols and possibly collected and analyzed by different facilities, presents the risk of increased errors and confusion. Consistency in standards and approach helps ensure that procedures are uniformly and consistently followed. HHS has produced no data to demonstrate that the longstanding urine testing program is inadequate or fails to achieve the government's need to accomplish drug testing.

Second, each type of alternative specimen collection has inherent problems. Oral fluid testing is not suitable for random, return-to-duty or follow-up testing. HHS recognizes that oral fluid testing may report incorrect results of marijuana and thus requires urine collection at the same time as the oral specimen. Allowing employees to be subject to testing of multiple bodily fluids at the same time is unduly burdensome. It is also unfair to put these employees at risk of being erroneously identified as marijuana users based on an inaccurate oral fluid test.

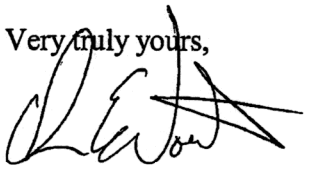
Sweat patch testing is also invasive and stigmatizing to employees. It may be equally if not more uncomfortable for individuals to have to submit to a stranger literally taking and examining the sweat produced from their bodies. Nor would any such collection avoid urine testing, nor save any such costs. Rather, as HHS recognizes, sweat patch testing is of limited usefulness for random, reasonable suspicion and post-accident testing. It is likewise unreasonable to require employees to produce multiple bodily fluids for governmental searches.

Hair testing is similarly of limited value. It is not suited for reasonable suspicion or post-accident testing. It is also unfair to use a testing method that admittedly is more likely to detect illegal drug use in dark-haired and dark-skinned individuals than light Caucasians. While no one should engage in illegal use, choosing to test by a method that unfairly impacts on people of different hair and skin color is not appropriate.

Significantly, none of these testing methodologies have been used in any broadscale workplace testing scheme. Each has recognized shortcomings and risks. HHS has presented no justification for authorizing use of these new, and largely untested technologies.

We submit that if HHS, nonetheless, authorizes the voluntary use of alternative specimen testing, any such testing should be held to the same standards of chain of custody, quality control, specimen validity tests, screening and confirmation as drug testing in urine. It should also be held to the same requirements for certification, inspection, proficiency and blind specimen testing.

Very truly yours,



Captain Duane E. Woerth
President

PRESIDENT'S DEPARTMENT
AIR LINE PILOTS ASSOCIATION, INTERNATIONAL
1625 MASSACHUSETTS AVENUE, N.W. ☐ WASHINGTON, DC 20036 ☐ 1-888-FLY-ALPA (1-888-359-2572)
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June 14, 2004

VIA FACSIMILE to 301-443-3031 and
E-MAIL to wvogl@samhsa.gov

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockwall II, Suite 815
Rockville, Maryland 20857

Re: FR Doc. 04-7985

Dear Sir or Madam:

These comments are submitted in response to the above-referenced revised Mandatory Guidelines for Federal Workplace Drug Testing Programs on behalf of the Air Line Pilots Association ("ALPA"), the principal union representing the nation's commercial pilots. ALPA represents more than 64,000 pilots at 42 airlines in the United States and Canada.

While ALPA maintains its objections to mandatory validity testing as stated in our prior comments to HHS in this rulemaking proceeding (October 22, 2001), we are glad to see that many of the serious concerns we have previously raised both to HHS and to the Department of Transportation ("DOT") have been addressed and incorporated in these mandatory guidelines. We appreciate and recognize the importance of the inclusion of the following protections in the final guidelines: (1) the employee right to split sample analysis of results reported as adulterated or "substituted" (using confirmation not screening tests) with cancellation of the result if not confirmed by the split analysis; (2) the requirement that MROs have applicable subject matter expertise; (3) MRO review of validity test results to determine whether such result can be explained by a legitimate medical explanation; (4) recognition that some individuals produce ultra-dilute urine and, as a result, lowering the creatinine cutoff from ≤ 5.0 to ≤ 2.0 mg/dL before a specimen can be reported as "substituted;" (5) the requirement to calibrate at 2.0 mg/dL for tests measuring creatinine; (6) the requirement for specimen validity testing controls at specified levels above and below each cutoff; (7) the requirement for confirmation by a second test, using a different methodology than the screening test, before any specimen is permitted to be reported as "adulterated;" and (8) the requirements for quality control and oversight of validity testing including but not limited to blind quality control specimens, proficiency tests under the national laboratory certification program, and the imposition of validity testing performance standards.

Attachment A

It is extremely troubling, however, that many of these protections were incorporated in the procedures only after innocent employees had been wrongly identified as rule violators. Some of these employees have been able to regain jobs only after substantial expenditures of time and money, while others' careers remain terminated. We strongly urge that the requirements of the rule be made retroactive, and that individuals with prior test results reported as adulterated or "substituted" be given a right to have those results cancelled upon a showing that such testing failed to comply with these regulatory standards.

While the mandatory guidelines contain many vital protections, some additional items should be addressed. First, it should be recognized that there is no scientific basis (or complete accord within the scientific community as shown at the Tampa meeting in February 2003) for identifying urine with creatinine less than 2.0 mg/dL as "substituted." DOT and SAMHSA were wrong in their prior claims that specimens with creatinine reported as less than 5.0 mg/dL could not be "human" urine, and ALPA so contended in numerous comments submitted over a period of years. Only after being forced to grapple with the claims and evidence from affected employees with ruined careers as well as the persistent critique of scientists, did the government finally alter that arbitrary standard. HHS should now recognize that 2.0 mg/dL is not a magic number below which individual wrongdoing is proven. To the contrary, data provided to HHS in October 2001 by the Association of Flight Attendants clearly demonstrated that in a sampling taken for an air quality study in 1998 and 1999 -- wholly unrelated to any drug testing issues or concerns -- two samples out of 85 tested had creatinine levels of 1.9 mg/dL and specific gravity of 1.001. (Attachment A hereto). This actual data evidences the real risk that employees face when treated as rule violators merely because their body produces urine that is more dilute than an arbitrary government cutoff level.

It should also be recognized that all tests, including those for creatinine, have a margin of error. HHS's proficiency testing permits a margin of error of $\pm$20% or $\pm$2 standard deviations. See Section 3.19, 69 Fed. Reg. 19669 (Apr. 13, 2004). Thus, if a known proficiency specimen of 2.2 mg/dL reported a result of 1.8 mg/dL it would satisfy the requisite performance standards. Likewise, the same equipment could report an employee's actual creatinine level of 2.2 mg/dL at 1.8 mg/dL, thus causing that person to be deemed a rule violator with the risk of loss of their career and livelihood. Such a result would be grossly unfair, and should be prevented.

In the face of the actual data demonstrating that unsuspecting individuals have creatinine as low as 1.9 mg/dL, the absence of any scientific support for an absolute cutoff, and in light of the grave harm suffered by real individuals who produce urine below the agency cutoff, we strongly urge that HHS's approach be reconsidered. Individuals whose creatinine is below 2.0 mg/dL should not be branded as wrongdoers but rather could be directed to submit to an immediate or subsequent unannounced, observed urine collection. Certainly, at a minimum, individuals whose creatinine level is reported below 2.0 mg/dL should have the right to provide medical evidence to exonerate themselves, a right that should be made explicit in the final regulations.

The final guidelines do not provide for a true confirmation test either of creatinine or specific gravity, but rather seek to use the specific gravity test as a confirmation of urine dilution. A more scientifically defensible approach would be to confirm urine dilution by measuring the osmolality of the specimen. Osmometers are one means of measuring urine dilution that is widely and generally accepted by the scientific community.

The final guidelines require the measurement of specific gravity to four decimal places. Requiring a greater degree of accuracy in such measurements would enhance the reliability of the reported results. The validity of the reported results would only be enhanced if specific gravity is an adequate way of measuring urine diluteness. The electronic refractometers used for such testing should first be evaluated by clinical studies to determine whether they have the requisite performance capability. Such study should be done prior to the use of that equipment for the broad scale employee specimen analysis required by this rule.

Very truly yours,

Captain Duane Woerth
President

Association of Flight Attendants, AFL-CIO
1275 K Street NW, Suite 500
Washington, DC 20005

FAX SUBMISSION

To: Robert L. Stephenson II, M.P.H.
Director, Division of Workplace Programs, CSAP
5600 Fishers Lane, Rockwall II, Suite 815
Rockville, MD 20857

From: Ann Tonjes, Manager, Policy Planning

Subject: Mandatory Guidelines for Federal Workplace Drug Testing Programs - Comments of the Association of Flight Attendants

Date: October 22, 2001

Pages: Eleven (11) pages

Attached please find a submission of ll pages. It includes a letter to the Secretary of the Department of Health and Human Services (HHS), the Honorable Tommy Thompson, from the International President of the Association of Flight Attendants, Patricia A. Friend, as well as an attachment of eight pages.

The original has been mailed to the Secretary and a copy mailed to you.

ATTACHMENT A

ASSOCIATION OF FLIGHT ATTENDANTS AFL-CIO
1275 K Street, NW, Washington, DC 20005-4006
PHONE 202•712•9798 FAX 202•712•9798

October 22, 2001

The Honorable Tommy Thompson, Secretary
Department of Health and Human Services (HHS)
200 Independence Avenue SW
Hubert H. Humphrey Building
Washington, DC 20201

Dear Mr. Secretary:

We are writing to share our perspective about the Department's proposed standards for mandatory validity testing - the Mandatory Guidelines for Federal Workplace Drug Testing Programs proposed by the Substance Abuse and Mental Health Services Administration's Division of Workplace Programs. We are submitting these comments on behalf of the Association of Flight Attendants, AFL-CIO, which represents flight attendants at 26 US carriers.

We believe in a drug-free workplace. Our very lives depend upon it. We are responsible for responding to any safety or security problem in the cabin - from an inflight fire to a violent or abusive passenger - and often work 12 to 16 hour days mostly on our feet. We must be able to evacuate an airplane in 90 seconds and now, tragically, perform our duties in the face of sophisticated terrorist threats.

The accuracy of mandatory workplace validity testing must be unassailable. But the proposed regulations are based on an incomplete assumption - that non-normal validity tests for substitution either result from a medical condition or tampering (an attempt to hide evidence of drug use). A third critical variable is excluded: an apparently healthy individual who has not tampered with the specimen but produces a substituted test result for reasons not taken into account by the proposed HHS standards.

These admittedly few employees who have done nothing wrong - except to produce urine test results which fall outside the parameters for "normal" - have an unqualified right not to be penalized merely because they produce ultra-dilute urine. An employee's ultra-dilute sample must be tested for the presence of illegal drugs at the DOT GC/MS cutoff level for an original sample, with the same protections as any other drug test, including the right to MRO review and split sample analysis.

We propose this solution to rectify the problems outlined below, which have not been addressed by the DOT or the HHS.

1-Impact of gender, ethnicity, weight and diet on substituted test results. In my January 26, 2000 letter to Secretary Slater, I asked if these issues had been addressed separately in developing validity testing standards. My letter was prompted by substituted test results from small female flight attendants of Asian descent who were vegetarians and who consumed

considerable amounts of water on long flights. The Department of Transportation's (DOT) water loading study included a diverse population but did not address differences among diverse categories of individuals. In addition, only 9 of the 54 participants were women weighing 115 pounds or less. Of these, four were white, two Hispanic, two African-American and one Asian. None appear to be vegetarians. In other words, the study did not address my concerns.

2-Impact of different laboratory procedures on test results. Reports from two flight attendants demonstrate that separate laboratories can reach significantly different results when testing the same sample. In the first instance, a flight attendant produced a sample with a creatinine level of 4.9 mg/dL and a specific gravity of 1.001. That test result was done by Advanced Toxicology Network. Her split sample was tested at Northwest Drug Testing. The results were a creatinine level of 2.9 mg/dL and a specific of 1.002.

A second flight attendant produced a substituted result with a creatinine level of 5 mg/dL and a specific gravity of 1.001. Because LabOne truncated the creatinine levels, the result was cancelled. The test of her split sample had a 5.3 mg/dL creatinine level and a specific gravity level of 1.002.

The first example demonstrates highly suspect variations in testing for creatinine levels - a 4.9 mg/dL at one laboratory and a 2.9 mg/dL at the other. The difference seems too extreme to be credible. In both cases the specific gravity level of the flight attendant test results changed. Each flight attendant had one acceptable measurement (1.002) and one unacceptable one (1.001) on the same sample.

The DOT water loading study fails to discuss whether or not split samples were collected. One of our members participated in this program. At one point, she was told she would obtain the results of the tests of her split samples. At another point, she was advised that split sample testing was too expensive and was not undertaken. From our perspective, if splits were collected but not tested, tests on the splits should be done immediately to sharpen our collective understanding of variation among laboratory results.

3-Normal Creatinine Levels. AFA has continued to receive reports of questionable substitution results. One flight attendant (described above) was terminated after producing a sample which had a creatinine level of 4.9 mg/dL and a specific gravity of 1.001. She was advised that she did not have the right to have her split sample tested because her original test had taken place before split sample testing for failed validity tests became mandatory in January, 2001. Her next step was an internal review process at her company, which involved assistance from individuals with expertise in validity testing, but she was not reinstated. After receiving a court order for the split to be tested, a different laboratory advised her that her sample had a creatinine level of 2.9 mg/dL and a specific gravity of 1.002; the same sample tested negative for drugs on both the immunoassay and the confirmation test.

A second flight attendant produced two substituted tests, the second under direct observation, a procedure designed to ensure that a substituted sample cannot result from tampering. Her first substituted sample had a creatinine concentration of 4.8 mg/dL and a specific gravity of 1.001. She passed a (directly observed) return-to-duty test after not flying for

three months, with levels of 5.6 mg/dL and 1.001. Her third test (observed) occurred after working again as a flight attendant for about three months; the result was another substituted test with levels of 4.9 mg/dL and 1.001.

This is not new information for either the DOT or the HHS; both individuals have been in repeated contact with high level officials in SAMHSA's Division of Workplace Programs and the DOT's Office of Drug and Alcohol Policy and Compliance.

Validity testing done on 85 urine samples confirms the problems identified above. In early October, AFA asked Pacific Toxicology Laboratories to test these samples - samples held in frozen storage by the laboratory following earlier tests for an unrelated AFA health project - for creatinine, specific gravity, nitrites and pH. Two separate individuals produced creatinine levels of 1.9 mg/dL and specific gravity levels of 1.001. (Attachment A)

None of these results are surprising. They are results which fall outside the bell curve of what is expected - what is normal - for 95% of the population. Our concern is the other 5%, who do not produce a "normal" test result through no fault of their own. As the Air Line Pilots Association (ALPA) pointed out, quoting a statement by Dr. Vina Spiehler, in their submission to the DOT on April 7, 2000, "the quantity of creatinine produced (and correspondingly the amount of creatinine excreted in one's urine) varies from person to person, and can vary by as much as 69.9% for a single person at different times as measured on spot urine tests". In addition, the ALPA submission notes that "women, on average, have lower levels of creatinine, and when they eat primarily vegetarian diets, consume great quantities of water, and are at a particular point in their menstrual cycle, may be at greater risk of having ultra-dilute urine, and being deemed to have 'substituted' their samples".

Our request is a modest one. We are merely asking for fair treatment for those who fall outside the bell curve - those whose test results are not consistent with the "normal" results expected for 95% of the population.

To exact punishment - unless the government can prove, beyond a reasonable doubt, that there was an attempt to falsify or an intent to deceive - is morally wrong. Termination of employment has often been called the 'capital punishment' of employee-management relations. If it is ever warranted, it must be based on unassailable evidence.

Thank you in advance for your consideration of our concerns.

Sincerely,

Patricia A. Friend
International President

cc: Robert L. Stephenson II, Director, Division of Workplace Programs

Attachment A - Page One of Eight
Association of Flight Attendants, AFL-CIO

Attached are the results of validity testing performed on 85 urine samples, provided by members of AFA, in connection with a project unrelated to validity testing. It goes without saying that the participants had no incentive to tamper with their samples.

The tests were done by Pacific Toxicology Laboratories.

The laboratory tested blood and urine samples provided by members of AFA in 1998 and 1999. AFA was looking at these employees after air quality incidents on board aircraft with potential exposure to hydraulic fluids and/or lubrication oil. At that time, the laboratory advised AFA of unusually low creatinine levels in some samples. AFA asked that the samples be frozen and stored because additional urine testing did not seem useful at that time.

The samples entered into the laboratory's Sample Archival Program and remained in a frozen state there.

Recently, William P. Knowles, an attorney working on AFA's air quality review, and I contacted the laboratory to ask that it run the standard validity test panel (tests for creatinine, specific gravity, pH and nitrites) on the stored samples. We asked that testing be done, to the extent possible, in accord with validity testing standards established by the federal government.

Last week these samples were thawed and entered in the laboratory's computer for testing in compliance with out request.

The laboratory results for this testing are attached. They show that two separate samples of the 85 tested had creatinine levels of 1.9 mg/dL and specific gravity of 1.001.

These results would be classified as substituted samples under federal guidelines. They reinforce AFA's argument that some individuals can fall outside the proposed standards for normal.

Ann Tonjes
Manager, Policy Planning
Association of Flight Attendants, AFL-CIO

From: "Roger Delgado" <rdelgado@pactox.com>
To: afa_dom.post1(ATONJES)
Date: 10/17/01 2:50PM
Subject: Laboratory report

Ms. Tonjes,

Please find attached laboratory report., per your request. test date: Oct 15, 2001

Roger A Delgado
PacTox

CC: afa_dom.SMTP("PACTOXPAUL@aol.com")

PACIFIC TOXICOLOGY LABOR
ADHOC REPORT

COMPANY: ASSOC. OF FLIGHT ATTENDANTS AFL-CIO
ATTN: WILLIAM P KNOWLES, ESQ

ACCESS NUMBER	DATE REC'D	DATE REPORTED	CREATININE URINE(FORENSIC) MG/DL	SPEC. GRAVITY URINE(FORENSIC)
R4007574	15-Oct-01	16-Oct-2001	118.4	1.024
R4007583	15-Oct-01	16-Oct-2001	62	1.012
R4007592	15-Oct-01	16-Oct-2001	65	1.011
R4007609	15-Oct-01	16-Oct-2001	12.2	1.005
R4007618	15-Oct-01	16-Oct-2001	73.2	1.014
R4007627	15-Oct-01	16-Oct-2001	34.7	1.02
R4007636	15-Oct-01	16-Oct-2001	217.8	1.04
R4007645	15-Oct-01	16-Oct-2001	22.1	1.007
R4007654	15-Oct-01	16-Oct-2001	111.3	1.021
R4007663	15-Oct-01	16-Oct-2001	49.5	1.009
R4007672	15-Oct-01	16-Oct-2001	141.9	1.022
R4007681	15-Oct-01	16-Oct-2001	321.8	1.028
R4007691	15-Oct-01	16-Oct-2001	154.3	1.02
R4007707	15-Oct-01	16-Oct-2001	33.3	1.008
R4007716	15-Oct-01	16-Oct-2001	71.6	1.012
R4007725	15-Oct-01	16-Oct-2001	94.6	1.022
R4007734	15-Oct-01	16-Oct-2001	96.2	1.015
R4007743	15-Oct-01	16-Oct-2001	136.9	1.021
R4007752	15-Oct-01	16-Oct-2001	157.9	1.026
R4007761	15-Oct-01	16-Oct-2001	118.8	1.024
R4007771	15-Oct-01	16-Oct-2001	30	1.006
R4007780	15-Oct-01	16-Oct-2001	1.9	1.001
R4007799	15-Oct-01	16-Oct-2001	126.4	1.018
R4007805	15-Oct-01	16-Oct-2001	136.5	1.026
R4007814	15-Oct-01	16-Oct-2001	117.2	1.024
R4007823	15-Oct-01	16-Oct-2001	96.2	1.012
R4007832	15-Oct-01	16-Oct-2001	81.9	1.016
R4007841	15-Oct-01	16-Oct-2001	24.6	1.005
R4007851	15-Oct-01	16-Oct-2001	76.7	1.013
R4007860	15-Oct-01	16-Oct-2001	22.9	1.007
R4007879	15-Oct-01	16-Oct-2001	80.5	1.014
R4007888	15-Oct-01	16-Oct-2001	129.3	1.018
R4007897	15-Oct-01	16-Oct-2001	20.1	1.004
R4007903	15-Oct-01	16-Oct-2001	52.9	1.012
R4007912	15-Oct-01	16-Oct-2001	24.1	1.006

R4007921	15-Oct-01	16-Oct-2001	17	1.003
R4007931	15-Oct-01	16-Oct-2001	78.4	1.018
R4007940	15-Oct-01	16-Oct-2001	19.6	1.006
R4007959	15-Oct-01	16-Oct-2001	25.3	1.008
R4007968	15-Oct-01	16-Oct-2001	45.7	1.012
R4008231	15-Oct-01	16-Oct-2001	70.8	1.024
R4008240	15-Oct-01	16-Oct-2001	89.6	1.026
R4008259	15-Oct-01	16-Oct-2001	129.6	1.028
R4008268	15-Oct-01	16-Oct-2001	52	1.018
R4008277	15-Oct-01	16-Oct-2001	67.1	1.02
R4008286	15-Oct-01	16-Oct-2001	169.3	1.03
R4008295	15-Oct-01	16-Oct-2001	34	1.008
R4008301	15-Oct-01	16-Oct-2001	33.9	1.008
R4008311	15-Oct-01	16-Oct-2001	128.3	1.028
R4008320	15-Oct-01	16-Oct-2001	50.4	1.008
R4008339	15-Oct-01	16-Oct-2001	90.4	1.024
R4008348	15-Oct-01	16-Oct-2001	147.5	1.028
R4008357	15-Oct-01	16-Oct-2001	31.4	1.006
R4008366	15-Oct-01	16-Oct-2001	22.9	1.005
R4008375	15-Oct-01	16-Oct-2001	91.9	1.022
R4008384	15-Oct-01	16-Oct-2001	153.8	1.03
R4008393	15-Oct-01	16-Oct-2001	101.7	1.026
R4008400	15-Oct-01	16-Oct-2001	16.2	1.003
R4008419	15-Oct-01	16-Oct-2001	36.6	1.008
R4008428	15-Oct-01	16-Oct-2001	133.8	1.022
R4008437	15-Oct-01	16-Oct-2001	51.7	1.01
R4008446	15-Oct-01	16-Oct-2001	68.9	1.012
R4008455	15-Oct-01	16-Oct-2001	34	1.006
R4008464	15-Oct-01	16-Oct-2001	58.1	1.008
R4008473	15-Oct-01	16-Oct-2001	20.5	1.004
R4008482	15-Oct-01	16-Oct-2001	157.7	1.028
R4008491	15-Oct-01	16-Oct-2001	48.8	1.01
R4008508	15-Oct-01	16-Oct-2001	39.8	1.006
R4008517	15-Oct-01	16-Oct-2001	238.7	1.04
R4008526	15-Oct-01	16-Oct-2001	108.4	1.024
R4008535	15-Oct-01	16-Oct-2001	20.4	1.003
R4008544	15-Oct-01	16-Oct-2001	21.5	1.004
R4008553	15-Oct-01	16-Oct-2001	32.3	1.005
R4008562	15-Oct-01	16-Oct-2001	22.4	1.004
R4008571	15-Oct-01	16-Oct-2001	137	1.026
R4008581	15-Oct-01	16-Oct-2001	10.8	1.003
R4008590	15-Oct-01	16-Oct-2001	1.9	1.001
R4008606	15-Oct-01	16-Oct-2001	29.1	1.005
R4008615	15-Oct-01	16-Oct-2001	40	1.005
R4008624	15-Oct-01	16-Oct-2001	176.8	1.028
R4008633	15-Oct-01	16-Oct-2001	16.9	1.003

R4008642	15-Oct-01	16-Oct-2001	16.2	1.003
R4008651	15-Oct-01	16-Oct-2001	53.9	1.008
R4008661	15-Oct-01	16-Oct-2001	32.6	1.005
R4008670	15-Oct-01	16-Oct-2001	20.6	1.009

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NITRITES, URINE(FORENSIC) UG/ML	pH, URINE(FORENSIC)
NEGATIVE	4.9
NEGATIVE	4.8
NEGATIVE	5.8
NEGATIVE	6.4
NEGATIVE	6.5
NEGATIVE	2.6
NEGATIVE	5.8
NEGATIVE	6
NEGATIVE	5.6
NEGATIVE	6
NEGATIVE	5.5
NEGATIVE	6.6
NEGATIVE	6.9
NEGATIVE	6.6
NEGATIVE	5.1
NEGATIVE	5.4
NEGATIVE	5.2
NEGATIVE	6.9
NEGATIVE	4.9
NEGATIVE	6.9
NEGATIVE	6.3
NEGATIVE	6.2
NEGATIVE	6.1
NEGATIVE	4.8
NEGATIVE	5.7
NEGATIVE	6.5
NEGATIVE	4.8
NEGATIVE	6.2
NEGATIVE	6.5
NEGATIVE	6.2
NEGATIVE	5.1
NEGATIVE	6
NEGATIVE	5.1
NEGATIVE	6.8
NEGATIVE	6.3

NEGATIVE	6
NEGATIVE	6.5
NEGATIVE	6.5
NEGATIVE	5
NEGATIVE	6.2
NEGATIVE	6.5
NEGATIVE	5.4
NEGATIVE	6
NEGATIVE	5.6
NEGATIVE	5.4
NEGATIVE	4.9
NEGATIVE	6.8
NEGATIVE	6.1
NEGATIVE	5.8
NEGATIVE	6.5
NEGATIVE	6.6
NEGATIVE	5
NEGATIVE	6.1
NEGATIVE	6.3
NEGATIVE	6.6
NEGATIVE	4.8
NEGATIVE	6.2
NEGATIVE	6.8
NEGATIVE	5.8
NEGATIVE	6.1
NEGATIVE	6.5
NEGATIVE	6.7
NEGATIVE	6.8
NEGATIVE	6.1
NEGATIVE	6.8
NEGATIVE	6.5
NEGATIVE	6.1
NEGATIVE	5.8
NEGATIVE	5.6
NEGATIVE	5.3
NEGATIVE	6.8
NEGATIVE	7
NEGATIVE	5.8
NEGATIVE	6.3
NEGATIVE	5.7
NEGATIVE	6.7
NEGATIVE	6.3
NEGATIVE	6.6
NEGATIVE	5.4
NEGATIVE	5
NEGATIVE	5.7

NEGATIVE	6.1
NEGATIVE	5.7
NEGATIVE	6.6
NEGATIVE	6.7