



Washington State Department of Health
 Public Health Laboratories
 Emergency Response
 Phone (206) 418-5481 Fax (206) 364-0072

PHL USE ONLY

PHL ALL HAZARDS ENVIRONMENTAL SAMPLE SUBMISSION CHAIN-OF-CUSTODY FORM

INSTRUCTIONS: All samples submitted to the Public Health Labs for testing **MUST** follow the Notification Procedure for Suspected Threat Incidents. You **MUST** receive verbal permission from the Washington State Epidemiology section prior to sending the sample. **All samples MUST be screened for EXPLOSIVES** prior to submission to the Public Health Labs. No samples will be accepted without this screening. All samples submitted for testing must include this fully completed submission form. Failure to fully complete this form may delay testing results.

SAMPLE INFORMATION		FIELD HAZARD SCREENS OF SAMPLE			
1. DESCRIPTION OF SAMPLE		ON-SITE INCIDENT SCREEN (Check if completed)	DATE/TIME	RESULTS	TECH ID
2. TYPE OF MATERIAL (check all that apply): <input type="checkbox"/> POWDER <input type="checkbox"/> SOLID <input type="checkbox"/> LIQUID <input type="checkbox"/> GAS <input type="checkbox"/> MIXTURE _____		9. Bomb Tech Screen* <input type="checkbox"/> (if unopened)			
		10. Explosives <input type="checkbox"/>			
3. COUNTY OF INCIDENT	4. DATE AND TIME OF COLLECTION ____/____/____ _____ am / pm	11. Reactive Chemicals <input type="checkbox"/>			
SUBMITTER INFORMATION					
5. SUBMITTING AGENCY		12. Chemical pH (wet) <input type="checkbox"/>			
6. SUBMITTER NAME		13. Radioactivity <input type="checkbox"/>			
7. PHONE NO ()	8. EMAIL	14. Volatile Organics <input type="checkbox"/>			

*** ALL SAMPLES MUST BE PRE-SCREENED FOR EXPLOSIVES PRIOR TO ENTRY INTO THE PHL ***

15. CHAIN OF CUSTODY-SAMPLE TRANSFER: (Each person receiving or relinquishing the sample must sign below)					
Relinquished Custody	Agency	Date/Time	Received Custody	Agency	Date/Time
Name: Signature:		____/____/____ _____ am / pm	Name: Signature:		____/____/____ _____ am / pm



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16. INTERNAL SAMPLE TRANSFER: (Each person receiving or accessing the sample must sign below) LABORATORY USE ONLY.

Relinquished by	Reason/Amount	Date/Time	Received By	Date/Time
Name: Signature:		____/____/____ _____ am / pm	Name: Signature:	____/____/____ _____ am / pm
Name: Signature:		____/____/____ _____ am / pm	Name: Signature:	____/____/____ _____ am / pm

Release or Destruction of Sample(s)

Upon final completion of all testing the submitter will be contacted regarding the release or destruction of the submitted sample(s) stated above. The Washington State Department of Health Public Health Lab will destroy the submitted sample(s) on behalf of the submitter. If destruction is desired, the submitter must complete the form below in-person or fax to (206) 364-0072.

Release of all Sample(s) must be picked up in person and cannot be mailed

	Relinquished Custody	Agency	Date/Time	Received Custody	Agency	Date/Time
17. <input type="checkbox"/> RELEASE	Name: Signature:		____/____/____ _____ am / pm	Name: Signature:		____/____/____ _____ am / pm
18. <input type="checkbox"/> DESTROY	Name: Signature:		____/____/____ _____ am / pm	Name: Signature:		____/____/____ _____ am / pm

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