

POST ACCIDENT TESTING DECISION REPORT

A separate sheet must be filled out for each covered employee that contributed to the accident

System Name: _____ Date of Accident: _____

Time of Accident: _____ Time Employer was notified: _____

Location of Accident: _____

Safety-Sensitive Employee: _____ ID # and Position: _____
i.e. Driver, Dispatcher, etc

1. Did the accident involve a revenue service vehicle? Yes No
2. Did the accident involve the operation of the vehicle? Yes No
3. Was there loss of life as a result of the accident? Yes No
4. Did an individual suffer a bodily injury and immediately receive medical treatment away from the scene? Yes No
5. Was there disabling damage to any of the involved vehicles? Yes No
6. a) Did you perform a drug and/or alcohol test?
(Use **Decision Tree on back of this form**) Yes FTA Authority Yes Company Authority No
- b) If no, why not? _____
7. a) Was an alcohol test performed within 2 hours? N/A Yes No
- b) If no, why: _____
8. If no alcohol test occurred, and more than 8 hours elapsed from the time of the accident, please explain: _____

9. a) Was a drug test performed within 32 hours? N/A Yes No
- b) If no, why: _____
10. a) Did the employee leave the scene of the accident without a reasonable explanation? Yes No
- b) If Yes, please explain: _____

Test Determination:

Name of supervisor making determination: _____

Time employee was informed of determination: _____

Signature & Title

Date

For your files: attach test results summary, order to test, Custody and Control Form (USDOT) and alcohol testing form (USDOT)