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? ☐ Yes FTA Authority ☐ Yes Company Authority ☐ No
   (Use Decision Tree on back of this form)

   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: ______________________________

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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)