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  [ ] No

   b) If no, why not? _______________________________________________________________________________________________________

   [ ] FTA Authority  [ ] Yes  [ ] No

   [ ] Company Authority  [ ] No

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)
Disabling Damage: Damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repairs.

1. Inclusion: Damage to a motor vehicle, where the vehicle could have been driven, but would have been further damaged if so driven.
2. Exclusions:
   A. Damage that can be remedied temporarily at the scene of the accident without special tools or parts.
   B. Tire replacement without other damage even if no spare tire is available.
   C. Headlamp or tail light damage.
   D. Damage to turn signals, horn, or windshield wiper, which makes the vehicle inoperable.

Contributing Factor: The determination of whether or not a safety-sensitive employee’s performance was a contributing factor should be the decision of the company official investigating the accident; not based on the police officer’s accident fault determination. This decision should not be made hastily. The company official’s determination must be based on the best available information at the time of the accident.