POST-ACCIDENT TESTING DETERMINATION FORM

The purpose of this form is to provide the immediate supervisor, manager or appointing authority guidance where an employee has caused or contributed to an on-the-job accident or unsafe, on-duty, job-related activity that meets either of the criteria in accordance with the Department of Administration's Drug-Free Workplace Program Operating Procedures.

Note: Supporting documents to support claim must be attached and a copies must be forwarded to DOA

PART A: EMPLOYEE INFORMATION (*To be completed by the Department/Agency EAP Representative)*

Date/Time of Incident or Work-related Accident: _____

Employee's Name: _____ **Social Security Number**: XXX-XX _____

Position Title: _____ **Date of Birth**: _____

Department: _____ **Section:** _____

Observing Supervisor's Name: _____

Second Observing Supervisor's Name: _____

QUESTIONS	YES	NO
1) Has the accident or unsafe practice resulted in a death or injury requiring hospitalization?	☐	☐
2) Has the accident or unsafe practice resulted in severe damage to government or private property in excess of $10,000?	☐	☐
3) Has on-the-job accident or unsafe, on-duty, job related activity, caused or contributed to an accident while transporting a member of the public?	☐	☐

****If Yes to any question, Drug testing is required****

Time Limits: A drug test should be administered as soon as practicable following the incident or accident.

a. **Drug Test:** If a drug test is not administered within 48 hours following the accident or incident, attempts to administer a drug test shall cease. If a drug test is not administered within the 48 hours limit, the supervisor shall document the reasons for delay.

PART B: ACCIDENT OR UNSAFE PRACTICE (*To be completed by the Department/Agency EAP Representative)*

A. Summarize the facts and circumstances of accident or incident, employees, supervisor actions, and any other pertinent information not previously noted on this form. Attached additional sheets as needed.

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Instructions: The department/agency designated Employee Representative (DER) can coordinate an Accident or Unsafe Practice "Post-Accident" test with the Department of Administration. This form must be immediately emailed, faxed or hand carried with supporting documents as soon as practical to the Drug-Free Workplace Coordinator.

Today's Date: _____

Immediate Supervisor's Name: _____ Immediate Supervisor's Signature:_____

Witness #1 Name (If applicable): _____ Witness #1 Signature: _____

Date: _____

Witness #2 Name (If applicable): _____ Witness # 2 Signature: _____

Date: _____

Appointing Authority Name: _____ Appointing Authority Signature: _____

Date: _____

PART C: EMPLOYEE STATEMENT (*To be completed by the Employee)*

C. Written Summary

Summarize the facts and circumstances of the accident or incident, employees, supervisor actions, and any other pertinent information not previously noted on this form. Attached additional sheets as needed.

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I acknowledge receipt of this form and have read and understood its contents. Failure to sign this form, does not indicate that I will not be subjected to drug testing.

Today's Date: _____

Employee's Name: _____ Employee's Signature:_____

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PART D: (*To be completed by the Department of Administration – Drug-Free Workplace Coordinator / EAP Administrator)*

_____ Signature of DOA DFWP Coordinator / EAP Administrator	DFWP – EAP STAMP RECEIVED:

	YES	NO
1) Did the department provide supporting documents related to the Post-Accident? (Police Report, etc.)	☐	☐
2) Did the employee provide statement of incident / accident?	☐	☐
3) Was a drug test scheduled?	☐	☐

********** NOTHING AS FOLLOWS **********