



POST-ACCIDENT TESTING FORM (CONFIDENTIAL)



Instructions: 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 that meets the criteria for post-accident testing in accordance with the Department of Administration’s Drug-Free Workplace Program. The supervisor shall complete and checkmark where appropriate, each applicable item and describe any facts or circumstances to warrant testing. A second observing witness is recommended. **The employee must be escorted to the testing facility by their supervisor or designated supervisory official. Under no circumstances is the employee allowed to go to the testing facility unsupervised.**

PART A: EMPLOYEE INFORMATION *(To be completed by the Employee’s Supervisor)*

Date/Time and Location of Accident While on Duty: _____

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

Position Title: _____ **Employee ID:** _____

Department: _____ **Section:** _____

Observing Supervisor’s Name & Position Title: _____

Witness Name and Position Title (If Applicable): _____

QUESTIONS - <i>**If any question from 1 to 5 is answered “YES”, testing may be authorized depending on responses to questions 6 and 7**</i>	YES	NO
1) Has the accident resulted in a death or personal injury requiring medical attention?		
2) Has the accident resulted in serious damage to government or private property?		
3) Did the accident involve a vehicle that required towing and was either driven or damaged by the employee?		
4) Did the accident involve a member of the public, or government employee, or minor, or hazardous materials?		
5) Did employee receive a citation, was arrested or indicted based on being involved in an accident?		
6) Based on Date and Time indicated above, did observations/incident occur within 32 hrs. for a drug test to be conducted? IF YES, A DRUG TEST WILL BE ADMINISTERED. If more than 32 hrs. has elapsed, no test is authorized - document reason for Delay in Part B		
7) Based on Date and Time indicated above, did observations/incident occur within 8 hrs. for an alcohol test to be conducted? IF YES, AN ALCOHOL TEST WILL BE ADMINISTERED. If more than 8 hrs. has elapsed, no test is authorized – document reason for Delay in Part B		

Drug test will be an unobserved collection. However, if there is belief that the employee may alter, tamper or substitute his/her urine specimen, the test can be conducted as a **direct observed collection** if justification is provided. Checkmark the box if test is to be conducted under direct observation and provide justification below and explain to the employee, otherwise leave blank:

Direct Observation Required:

Justification: _____

PART B: REASON FOR DELAY *(To be completed by the immediate supervisor)*



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PART C: ACCIDENT SUMMARY *(To be completed by the Employee's Supervisor)*

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

PART D: EMPLOYEE WRITTEN STATEMENT *(To be completed by the Employee/Employee's Supervisor)*

Employee's opportunity to provide an explanation below for his/her actions in relation to the accident which led his/her department to authorize post-accident drug and/or alcohol testing. Either the employee can fill this section or the employee's supervisor based on his/her meeting with the employee. **If a substantial amount of time is needed, the employee can submit a statement no later than one business day after the drug and/or alcohol test is conducted. The testing should not be unnecessarily delayed.**

I hereby confirm that I have read this form, or the form has been reviewed with me, and I understand its contents. I acknowledge that failure to sign this form does not exempt me from being subject to testing. I am aware that if I do not pass my test or if I refuse to be tested, disciplinary action will be taken against me. I am also aware that I may be subjected to direct observation specimen collection if it is check marked and justification is indicated on this form.

Print Employee's Name

Employee's Signature

Date: _____

FOR OFFICIAL USE BY EMPLOYEE'S SUPERVISOR/DEPARTMENT OFFICIAL

If Employee Refuses any part of the Testing Process, indicate below:

Employee was tested, but Refused to Sign Form _____

Employee Refused to be tested, but signed Form _____

Employee Refused to be tested and did not sign Form _____

Date, Time and Location Employee Refused Any Part of Testing Process: _____

Completing Dept Official – Print Name, Sign & Date: _____



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PART E: SUPERVISOR, WITNESS & APPOINTING AUTHORITY SIGNATURES

(To be completed by the Department)

Instructions: The department/agency's Designated DFWP Official Coordinator shall coordinate the Post-Accident test(s) with the Department of Administration. This form must be immediately emailed, or hand carried with supporting documents as soon as practical to the DOA HR Drug Testing Specialist within the deadlines stated on the first page of this Form. **Employee must be escorted to the testing facility by the employee's supervisor or designated supervisory official. Under no circumstances is the employee allowed to go to the testing facility unsupervised.**

Today's Date: _____

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

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

Date: _____

Agency Director's Name: _____ Agency Director's Signature: _____

Date: _____

PART F: DEPARTMENT OF ADMINISTRATION *(To be completed by the Drug Program Specialist)*

QUESTIONS	YES	NO
1) Did the dept provide supporting documents? (Police Report, photos, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2) Did the employee provide statement of incident / accident?	<input type="checkbox"/>	<input type="checkbox"/>
3) Was a Drug Test scheduled? If, no, explain.	<input type="checkbox"/>	<input type="checkbox"/>
4) Was an Alcohol Test scheduled? If, no, explain.	<input type="checkbox"/>	<input type="checkbox"/>
5) Did employee refuse any part of testing process that is different from what maybe marked on page 2? If yes, explain.	<input type="checkbox"/>	<input type="checkbox"/>
<p>_____ Signature of DOA Drug Program Specialist</p>	<p>DFWP – STAMP RECEIVED:</p> 	