Connecticut DRUG & ALCOHOL CONSORTIUM

# POST-ACCIDENT DRUG AND ALCOHOL TESTING
# DECISION MAKING FORM

The Connecticut Drug & Alcohol Testing Consortium, administered by Greater Hartford Transit District and in accordance with the Anti-Drug & Alcohol Misuse Policy adopted by your Transit's governing board requires that employees involved in a vehicle accident (as defined in the Policy) submit to tests for alcohol and prohibited drugs as soon as possible following an accident. The Policy also requires the testing of any other safety-sensitive employee whose performance could have contributed to the accident, as determined by the manager or supervisor at the scene using the best information available at the time of the decision.

**DATE OF ACCIDENT:** _____ **TIME OF ACCIDENT:** _____ ☐ AM ☐ PM

**EMPLOYEE NAME:** _____ **EMPLOYEE ID #:** _____

**DECISION QUESTIONS:**

- Was there a fatality? ☐ YES ☐ NO If *YES,* Post-Accident tests are required.
- If there was no fatality, ask the following questions:

1. Has any individual suffered a bodily injury and immediately received medical treatment away from the scene of the accident? ☐ YES ☐ NO
2. Was there disabling damage* to the company vehicle or any other vehicle as a result of the occurrence and the vehicle was transported away from the scene by a tow truck or other vehicle? ☐ YES ☐ NO

   *Damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repair; or damage to any vehicle that could have been operated but which would have further damaged the vehicle if so operated. Disabling damage does **not** include damage that could be remedied temporarily at the scene of the occurrence without special tools or parts; tire disablement even if no spare tire is available; or damage to headlights, tail lights, turn signals, horn, or windshield wipers that makes them inoperative. § 49 CFR Part 655.4

3. If the mass transit vehicle is a rail car, trolley bus, or vessel, was the vehicle removed from operation? ☐ YES ☐ NO

If you checked **YES** for questions 1, 2, or 3 above, Post-Accident tests are required under FTA rules unless you determine, using the best information available at the time of the decision, that the employee's performance can be completely discounted as a contributing factor to the accident.

**PLEASE NOTE:** Any reason for **NOT** conducting a Post-Accident test after you've answered **YES** to any of the above questions **MUST** be documented on the reverse side of this form.

☐ **OCCUPATIONAL DRUG TESTING MOBILE ON-SITE CALLED: 800.967.3135**

☐ **EMPLOYEE TAKEN TO** _____ (Collection Site)

**BY** _____ **TITLE** _____ **AT** _____ ☐ AM ☐ PM

PLEASE COMPLETE REVERSE SIDE

**FTA regulations require that testing is performed as soon as possible following the accident.**

If alcohol testing is not conducted within 2 hours after the accident, you must document the reason for the delay below. If the alcohol test is not administered within 8 hours, and the drug test within 32 hours, you must cease all efforts to administer the tests and document the reason(s) why the tests were not administered within the prescribed time frames.

## REASON ALCOHOL TEST WAS NOT CONDUCTED WITHIN 2 HOURS OF THE ACCIDENT:

**UPDATE THS STATEMENT IF NO TEST CONDUCTED WITHIN 8 HOURS.**

_____

_____

_____

## REASON DRUG TEST WAS NOT CONDUCTED WITHIN 32 HOURS OF THE ACCIDENT:

_____

_____

_____

**REASON THE EMPLOYEE'S PERFORMANCE WAS COMPLETELY DISCOUNTED AS A CONTRIBUTING FACTOR TO THE ACCIDENT AND THEREFOR FTA POST-ACCIDENT TESTING WAS NOT CONDUCTED:**

_____

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_____

## TESTING PROCEDURES:

_____ Determine if employee requires medical attention.

_____ Bring employee into a private setting if possible and inform him/her that (s)he will be transported to a collection site, or the mobile testing vehicle has been arranged to come on-site, for a drug and alcohol test in accordance with DOT-mandated procedures.

_____ If employee refuses to submit to testing, inform the employee that refusal to comply or cooperate is treated as a positive test, and will result in discipline up to and including termination.

_____ Complete and sign this form and forward the original to the company Drug & Alcohol Program Manager (DAPM)/Designated Employer Representative (DER).

**PLEASE RESPECT THE PRIVACY OF THE EMPLOYEE AND THE INTEGRITY OF THE TESTING PROGRAM. KEEP ALL MATTERS CONFIDENTIAL AND DISCUSS ONLY WITH PARTIES ON A "NEED TO KNOW" BASIS.**

_____ _____

**ON-SITE DECISION MAKER** **TITLE**

_____ _____

**DATE** **DEPARTMENT/DIVISION**