

Post-Accident Testing Determination & Decision Form for FTA Authorized Testing

Date _____ Time: _____ AM/PM

Employee(s) involved: _____ (please use proper name)

Supervisor's Description of the Accident:

Testing Determination Process:

1. Was the event the result of the operation of a vehicle? Yes _____ No _____ (If no, FTA drug and alcohol testing is prohibited)

2. Was there a fatality? Yes _____ No _____ (If yes, FTA drug and alcohol testing is required)

3. If there was NO fatality, answer the following two questions:

A. Did any individual involved in the accident suffer bodily injury and immediately receive medical treatment away from the scene of the accident?

Yes _____ No _____

B. Did any other vehicle involved in the accident sustain disabling damage, which required the vehicle to be transported away from the scene by a tow truck or other vehicle?

Yes _____ No _____

If you answered no to both A & B, testing is prohibited. If you answered yes to either A or B: Can the actions of the operator or any other covered employee on the vehicle be completely discounted as a contributing factor?

Yes, discounted _____ (If yes, FTA testing is prohibited)

No, cannot discount _____ (If no, FTA drug and alcohol testing is required)

If you have discounted the covered employee's actions, you must provide your reason:
