

POST-ACCIDENT REPORT

Employee:	Name:	_____		
	Social Security Number:	_____		
Location:	_____			
	(Street)	(City)	(State)	(Zip)

This report is to be completed when a post-accident alcohol test (conducted within 2 hours but no later than 8 hours) and a post-accident drug test (conducted within 32 hours) are required following an accident. Please complete the appropriate information.

Accident involved:

1. fatality;

OR

2. the driver receives a citation under state or local law for a moving traffic Violation arising from the accident and if the accident involved:

a. bodily injury to a person who, as a result of the injury, immediately receives treatment away from the scene of the accident

OR

b. one or more vehicles incur disabling damage requiring the vehicle to be transported away from the scene by a tow truck or other vehicle,

Date of Accident: _____

Time of Accident: _____

Location of Accident: _____

Please state the reasons why the post-accident alcohol test was not completed within two (2) hours:

Was the post-accident alcohol test completed within eight (8) hours? Yes No

If the post-accident test was not completed within eight (8) hours, please state the reason why the test could not be administered within eight (8) hours.

Could a blood alcohol test have been completed within eight (8) hours? Yes No

If yes, please provide the name, address and telephone number of testing site where the blood test could have occurred.

Was a post-accident drug test conducted within 32 hours following the accident? Yes No

If a post-accident drug test was not administered within 32 hours, please state the reasons why the test was not completed within 32 hours.

COMPLETED BY: _____

DATE _____

phone # _____