

STEPS TO FOLLOW WHEN YOU ARE INVOLVED IN AN ACCIDENT

(Place in the cab of truck)

DRIVER'S NAME: _____

TERMINAL LOCATION: _____

GENERAL INSTRUCTIONS

1. Use warning devices to protect scene.
2. Assist injured persons, do not move them unless absolutely necessary.
3. Notify police and other emergency personnel.
4. Identify yourself and company. Show your driver's license and registration.
5. Be courteous but make no statements except to police and company representatives. Do not discuss or admit fault.
6. Get names of witnesses. Record their information on the reverse side of this form.
7. Complete the Preliminary Accident Report on the reverse side of this form.
8. Call your supervisor at once.

You must submit to:

1. a post accident *drug test* (within **2 hours**, but **no later than 32 hours**), **AND**
2. a post accident *breath alcohol test* (within **2 hours**, but **no later than 8 hours**)

IF any of the following apply:

- (1) A FATALITY has occurred; **OR**
- (2) A TRAFFIC CITATION is issued to the CMV driver involved in a nonfatal accident **AND**
 - (a) There is bodily injury to a person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; **OR**
 - (b) One or more motor vehicles incurs *disabling damage* as a result of the accident, requiring the vehicle to be transported away from the scene by a tow truck or other vehicle.

If Post Accident Drug and Breath Alcohol Testing is required, ensure that the specimen is sent to:

MedTox Laboratories, Inc.
402 W. County Road D
St. Paul, MN 55112
(651) 636-7466 (800) 832-3244

Inform the testing facility that Hiland's Medical Review Officer is:

Eleanor Gilbert, M.D.
Workforce QA MRO Services
1430 S Main Street
Salt Lake City, UT 84115
PH (888) 249-4575 FX (801) 994-9953

PRELIMINARY ACCIDENT REPORT

(To Be Completed At the Scene of the Accident)

DATE: _____ TIME: _____ ☐ a.m. ☐ p.m.

ACCIDENT LOCATION ADDRESS: _____

OUR VEHICLE INFORMATION

DRIVER'S NAME: _____ VEHICLE NUMBER: _____

If you were required to take a post accident drug and alcohol test as defined on the reverse side of this form, list the name and address where you submitted to the screening:

Name of Testing Facility: _____

Address of Testing Facility: _____

Phone Number of Testing Facility: _____

NOTE: Be sure to tell the lab that you need to take a **FEDERAL D.O.T.** post accident drug screen **AND** a breath alcohol test performed by a Certified Breath Alcohol Technician.

OTHER VEHICLE INFORMATION

Driver's Name: _____ Age: _____

Address: _____

Phone Number: _____ Driver's License Number and State: _____

Owner's Name, (if other than the Driver): _____

Address and Phone Number: _____

Vehicle Make, Model and Year: _____

Vehicle License Plate Number and State: _____

Other parties insurance company's name, address, phone number and policy number:

Damage Description: _____

Witnesses names, addresses and phone numbers: _____
