Courtesy Card Example

Courtesy card or a business card with the contact number for dispatch are both best practices.

Courtesy Card
Thank you for using our services. If you have concerns or suggestions to help us better serve you, we would greatly appreciate you filling out this card and returning it.
Today's Date _____
Bus No. or Volunteer Driver Name _____
City _____
County _____
Remarks — What happened?_____
_____
_____
_____
_____

Optional
Your Name_____
Home Phone_____
Work Phone_____

Driver Visor Reminder Example

This is meant to be a 'brain tickler' to help trigger immediate actions based on the ongoing training delivered by your agency. It is not meant to be a comprehensive list, only to ensure that drivers are able to act in response to critical items when they may be experiencing symptoms of shock.

In the event of a crash:

1 – 911 and dispatch
2 – check yourself for injury
3 – passenger safety
4 – bus in harm's way?
5 – ensure help is on the way

POST-ACCIDENT TESTING DETERMINATION FORM

To be completed by the Supervisor/Company Official assigned to investigate the accident/incident.

Return to _____ *within 24 Hours of the accident/incident.*

1) Accident/Incident Report #: _____

2) Location of Accident/Incident: _____

_____

3) Detailed Description of Accident/Incident: _____

_____

4) Date of Accident/Incident: _____ Time: _____

5) Accident/Incident Report Date: _____ Time: _____

6) Name of Employee: _____

7) Employee Identification Number (not SSN#): _____

8) Employee's safety-sensitive function and job title: _____

9) Circumstances of Accident/Incident:

49 CFR Part 655.4 Definitions. **Accident** means an occurrence associated with the operation of a vehicle, if as a result: (1) An individual dies; or (2) An individual suffers bodily injury and immediately receives medical treatment away from the scene of the accident; or (3) With respect to an occurrence in which the mass transit vehicle involved is a bus, electric bus, van, or automobile, one or more vehicles (including non-FTA funded vehicles) incurs disabling damage as the result of the occurrence and such vehicle or vehicles are transported away from the scene by a tow truck or other vehicle.

(a) Was there a fatality? ____**Yes [If yes, go to (e) below] ____ No [If no, go to (b) and (c) below]

**If the accident resulted in a fatality of any person involved in the accident/incident (employee, passenger, or general public) the transit driver, and any other covered employee who may have been a contributing factor to the accident, will be required to undergo both a post-accident alcohol test and post-accident drug test. Every effort should be made to conduct the alcohol test before the drug test.

(b) Was anyone transported from the scene of the accident for medical attention? ____Yes ____No

If yes, any covered employee who cannot be discounted as a contributing factor to the accident is required to undergo both a post-accident alcohol and a post-accident drug test. Go to (d).

(c) Was there disabling damage* to any vehicle involved? ____Yes ____No

If yes, any covered employee who cannot be discounted as a contributing factor to the accident is required to undergo both a post-accident alcohol and post-accident drug test. Go to (d).

49 CFR Part 655.4 Definitions. Disabling Damage** means damage that precludes departure of a motor vehicle from the scene of the accident in its usual manner in daylight after simple repairs; or damage to a motor vehicle, where the vehicle could have been driven, but would have been further damaged if so driven. ***Exclusions: (i) Damage that can be remedied temporarily at the scene of the accident without special tools or parts. (ii) Tire disablement without other damage even if no spare tire is available. (iii) Headlamp or tail light damage. (iv) Damage to turn signals, horn, or windshield wipers, which make the vehicle inoperable.

Description of Disabling Damage: _____

_____

If NO checked for (a) and (b) and (c) above, then no testing is allowed under FTA authority.

Supervisor Making Determination: _____ Date _____

POST-ACCIDENT TESTING DETERMINATION FORM

If YES checked for (b) or (c) above:

(d) Could the driver have been a contributing factor to the accident? ____ Yes ____ No

YES: If you determine the driver could have been a contributing factor to the accident, then testing is required under DOT-FTA authority.

NO: If you determine the driver was **not** a contributing factor to the accident, document in detail below.

_____

_____

(e) Could any other safety-sensitive employee (e.g., mechanics) have been a contributing factor to the accident (as determined using information available at the time of the accident)? ____ Yes ____ No

10) Was the driver or other covered employee sent for post-accident alcohol **and** drug testing? ____Yes ____No

Was testing performed under DOT-FTA authority using DOT-Federal forms? ____Yes ____No

Was testing performed under independent Employer/Company Authority? ____Yes ____No

If YES, must use non-DOT/non-Federal testing forms and authorized in Employer's Drug & Alcohol Testing Policy

11) Supervisor Making Determination: _____ Date _____

12) Employee Notification of D&A Testing: Date: _____ Time: _____

13) Alcohol Test Conducted: Date: _____ Time: _____

14) Drug Test Conducted: Date: _____ Time: _____

15) Did the employee(s) refuse to test? ____Yes ____No

If Yes, explain: _____

16) Did the employee leave the scene of the accident without just cause? ____Yes ____No

If Yes, explain: _____

17) Did either the drug or alcohol test occur more than two hours from the time of the accident? ___Yes ___No

If Yes, explain: _____

18) If an alcohol test was <u>not</u> conducted within 8 hours of the accident, explain below as required by Part 655.44:

_____

19) If a drug test was <u>not</u> conducted within 32 hours of the accident, explain below as required by Part 655.44:

_____

20) Is the employee involved currently taking any Prescribed or Over-the-Counter medicines? ____Yes ____No

To Be Completed By DAPM/DER **Alcohol** Test Result: _____ **Drug** Test Result: _____

Attachments: _____Order for Testing _____Accident Report _____Test Result Summary

_____ Alcohol Testing Form (ATF) _____Drug Testing Custody and Control Form (CCF)

EMPLOYER NAME/LOGO

Drug and Alcohol Testing Notification

The Federal Transit Administration (FTA) drug and alcohol testing regulation (49 CFR Part 655) requires all covered employees submit to drug and alcohol testing as a condition of employment performing a safety-sensitive function.

Employee Information:

Employee Name: _____

Employee **ID**#: _____

Date of Notification: _____ Time of Notification: _____ AM/PM

Location of Employee when notified: _____

Employee Transported? _____ NO ____YES Transported by: _____

Collection Site Information: Expected Time of Arrival: _____ AM/PM

Name: _____

Address: _____

City, State, Zip: _____

Order for Testing:

Type of Test: ❑ Alcohol ❑ Drug ❑ **Both** Drug & Alcohol

Testing Authority: ❑ DOT-FTA ❑ Non-DOT

Test Type: ❑ Pre-Employment (drug) ❑ Random ❑ Post-Accident

❑ Reasonable Suspicion ❑ Return-to-Duty (observed) ❑ Follow-up (observed)

Observed Collection: ❑ YES ❑ NO

To be filled out by collection site check-in/registration staff:

Employee's Actual Time of Arrival at collection site (check-in): _____ AM/PM

Name/Initials of staff at check-in desk: _____

Return this form with the Employer Copy of the CCF and/or ATF to:

DER Name: _____

Employer Address:_____

Employer City, State, Zip: _____

Reason employee arrived at collection site **after** expected time of arrival: _____

_____

Order for Drug and Alcohol Testing

Name of Collection Site: _____

Collection Site Address: _____

Test Date: _____

Employee Arrival Time: _____ ***(to be completed at collection site's check-in location and returned to the DER with the Employer's Copy of the CCF or ATF)***

Covered Employee/Donor Information

Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Identification Number: _____ (CDL for FMCSA only)

Date of Birth: _____

Reason for Test:

☐ Random ☐ Pre-Employment (drug) ☐ Post-Accident ☐ Reasonable Suspicion

☐ Drug Test to be conducted under **observation**

☐ Return-To-Duty (After previous DOT violation - Mandatory Observation Required)

☐ Follow-Up (After previous DOT violation - Mandatory Observation Required)

Type of Test to Be Conducted: (DOT 49 CFR Part 40)

☐ DOT Drug Urine Specimen ☐ Non-DOT Drug Urine Specimen (per Employer Policy)

☐ DOT Breath Alcohol ☐ Non-DOT Breath Alcohol (per Employer Policy)

DOT Agency Authority (Check Only One):

☐ FTA (Federal Transit Administration-49 CFR Part 655)

☐ FMCSA (Federal Motor Carrier Safety Administration-49 CFR Part 382)

Employer Information

Employer Name: _____

Contact Person (DER):_____

Address: _____

City, State, Zip _____

Phone (Office): _____ (Mobile): _____

Call Designated Employer Representative (DER) upon confirmation of **alcohol test result ≥ 0.02**.

Injury Report

Please print clearly. Complete and turn this form in to your supervisor.

To be completed by employee:

1. GENERAL INFORMATION ☐ Passenger Injury ☐ Participant Injury

Name_____ Home Telephone #_____

Home Address_____

Exact Location of Accident_____

Date of Accident_____ Time of Accident_____

Injury Reported to _____ Injury Report Date _____ Injury Report Time_____

2. DESCRIPTION OF INJURY *(Be as specific as possible.)*

Type of accident (fall, etc.)_____

Type of Injury (sprain, etc.)_____

Body part(s) affected_____

Was first aid administered? ☐ Yes ☐ No

If yes, by whom? _____

Was immediate medical attention needed? ☐Yes ☐ No

If yes, who administered the medical attention?_____

3. DESCRIPTION OF INCIDENT

What happened? How did it happen? Was the incident caused by equipment malfunction? Specify what job was being performed. _____

_____

_____

Name(s) of witnesses. (Use comment cards for witness statements) _____

_____

Employee's Signature _____ Date_____

4. *To be completed by supervisor:*

*Date video viewed*_____

*What was the cause of the incident?*_____

_____

*Contributing factors (physical surroundings, etc.)*_____

_____

Did the employee violate safety regulations or instructions? ☐ Yes ☐ No

If yes, which ones?_____

_____

*What actions will be taken to prevent a recurrence?*_____

_____

*What other concerns do you have about this injury, if any?*_____

_____

*Supervisor's signature*_____ *Date*_____

*Bus #*_____ *Run name*_____

Vehicle Accident Report

Date_____ Time_____ Driver Name_____
VIN #_____ Driver's License #_____
License Plate # _____ Model_____ Year_____
Location_____
Weather conditions (check all that apply): _____*Clear* _____*Raining* _____*Snowing*
_____*Sleeting* _____*Dust/Smoke* _____*Fog*
_____*High Wind* _____*Other*
Road Surface: _____*Asphalt* _____*Concrete* _____*Gravel* _____*Dirt*
Road Conditions: _____*Dry* _____*Wet* _____*Icy* _____*Snow Covered* _____*Other*
Traffic Control: _____*Yes* _____*No* Describe_____
Seat Belts Fastened Driver: _____*Yes* _____*No* Passengers: _____*Yes* _____*No*
Photos taken at scene _____*Yes* _____*No* (photos should include all vehicles and/or any stationary items involved)

OTHER DRIVER INFO
Driver Name_____ Driver's License #_____
Driver Address_____ Driver Phone #_____
Driver Insurance Company_____ Policy #_____
Description of Other Vehicle_____ License Plate #_____

Briefly describe what happened. Indicate movement of involved vehicles. Provide a sketch in the box on the next page.

Injuries to driver and/or passengers:

Was there any exposure to blood or other body fluids? _____*Yes* _____*No*

Was proper protection used in dealing with this situation? _____*Yes* _____*No*

If any other property was damaged, please note and describe. Also state ownership of that property.

ASSISTING POLICE OFFICER INFO
Name_____ Badge #_____ Headquarters_____
Phone #_____
Police report made _____*Yes* _____*No*
Citation Issued _____*Yes* _____*No*
If so, what for? _____

Driver's signature _____ *Date*_____
*Supervisor's signature*_____ *Date viewed video*_____

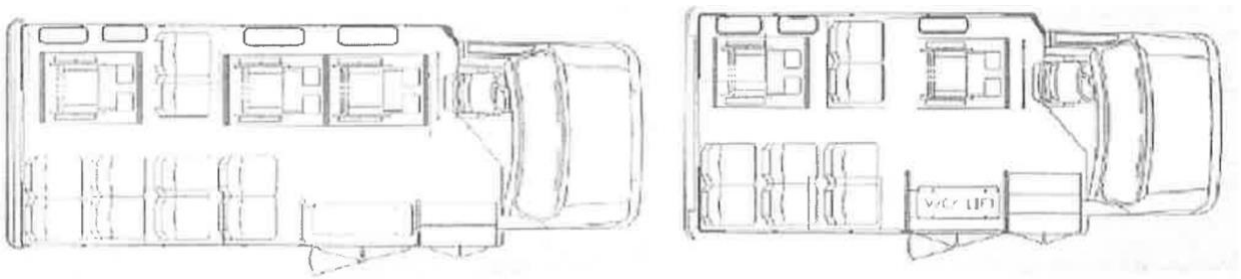
Add names of passengers and witnesses on the next page. Indicate bus damage on diagrams.

*Name*_____ *Age*___ *Name*_____ *Age*___
*Address*_____ *Address* _____
Phone # _____ *Phone #* _____
___ *Bus Passenger* ___*Vehicle Passenger* __*Witness* ___ *Bus Passenger* ___*Vehicle Passenger* __*Witness*
*Describe any injuries*_____ *Describe any injuries*_____
_____ _____
Was immediate medical attention needed? __*Yes* __*No* *Was immediate medical attention needed?* __*Yes* __*No*

*Name*_____ *Age*___ *Name*_____ *Age*___
*Address*_____ *Address* _____
Phone # _____ *Phone #* _____
___ *Bus Passenger* ___*Vehicle Passenger* __*Witness* ___ *Bus Passenger* ___*Vehicle Passenger* __*Witness*
*Describe any injuries*_____ *Describe any injuries*_____
_____ _____
Was immediate medical attention needed? __*Yes* __*No* *Was immediate medical attention needed?* __*Yes* __*No*

Sketch

Please note where damage was done to the bus.



Incident Report

Use this form when:

- √ A bus driver is involved in a situation with a passenger or member of the community.
- √ Passengers are breaking policy.
- √ A driver is involved in a near miss.
- √ A driver witnesses wrong behavior of a coworker.

Date_____ Time_____

Driver Name_____ Vehicle identification_____

Passenger(s) name(s)_____

Describe what happened in detail:

Explain what action(s) you took:

Were you exposed to any body fluids? (Circle one) YES NO

Driver Signature _____ Date_____

This section to be filled out by supervisor.

Time reported to supervisor_____

Action taken by supervisor:

Was the incident reported to the authorities? (Circle one) YES NO

If yes, who and when: