# Use this form to document employee Drug and Alcohol testing as the result of a PHMSA or FMCSA incident or accident, as defined by the Company’s [*Anti-Drug and Alcohol Misuse Prevention Plan (PHMSA)*](http://kmonline/human_resources/Documents/KINDER_MORGAN_PHMSA_ALCOHOL_DRUG_PLAN.pdf)or [*FMCSA Drug and Alcohol Drug Plan*](http://kmonline/human_resources/Documents/KINDER_MORGAN_FMCSA_ALCOHOL_DRUG_PLAN.PDF). Document all personnel performing a covered function associated with the accident, the Operator’s decision to test applicable employee\*, if the employee was or was not tested within the required timeframe (refer to the [Post–Accident Supervisor Written Record](http://kmonline/human_resources/Documents/KINDER_MORGAN_PHMSA_ALCOHOL_DRUG_PLAN.pdf) PDF document attached to the Anti-Drug and Alcohol Misuse Prevention Plan)\*\*, and the reason why certain employees were not tested\*\*\*. An Operator must drug test each surviving covered employee whose performance of a covered function either contributed to the accident or cannot be completely discounted as a contributing factor to the accident. An Operator may decide not to test an employee but such a decision must be based on specific information that the covered employee’s performance had no role in the cause(s) or severity of the accident. This record must be maintained for 3 years. Upon completion, upload document into the SC Incident system.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Accident Date: |  |  | Accident Name (if applicable): |  | | |
| Operating Company: |  |  | System or Facility Name: |  | | |
| MP or GPS Coordinates: |  |  | County: |  | | |
| Address (if applicable): |  |  | City: |  | State: |  |
| Description of Accident: |  |  |  |  | | |

| **Department**  (e.g., Control Room, Engineering, Operations, Contractor) | **Function Performed**  (e.g., Replacing Component, Valve Maintenance) | **Employee Name** | **\*Test Y/N** | **\*\*Tested within required timeframe?**  **Y/N** | **\*\*\*Reason for not testing** | **Comments** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Completed by: |  |  | KM Employee ID: |  |
| Signature: |  |  | Date Form Completed: |  |
| Reviewing Supervisor Signature: |  |  | Date Form Completed: |  |