# 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.

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