Northwest Ironworkers Health and Security Fund
Drug Free Workplace Program

Phone (877) 213-8630 or (503) 742-2410 • Fax (503) 742-2415

Administered by
Welfare & Pension Administration Service, Inc.

POST-ACCIDENT TESTING REPORT INFORMATION

Involvement in an on-the-job accident may require testing when an employee is judged to have caused or contributed to an accident requiring off-site medical attention or property damage. If an employee is sent for a Post-Accident Test:

1. Complete the Documentation Form (attached.)

2. Contact the DFW office and provide the name of the Ironworker being tested. The DFW office can provide you with information regarding the nearest collection site, if needed, and will notify you when they receive the Ironworker's test results.

   Note: No drug or alcohol tests are to be administered prior to necessary medical treatment. Once medical treatment is complete, the employee can be taken to an authorized DFW collection site.

   Once you are at the collection site:
   - **ASK FOR A 10-PANEL /POST-ACCIDENT TEST.**
   - **TELL COLLECTION SITE TEST NEEDS TO BE DONE FOR "PACIFIC NORTHWEST IRONWORKERS" (Legacy MetroLab Account #16025).**

3. After the test is completed, the employee may be transported back to their residence or the jobsite.

4. The Employee must report for testing as directed by the Employer within two (2) hours of receiving any needed medical treatment. If no medical treatment is required, then the employer may only direct the Employee to test within twenty-four (24) hours of the accident or event and the Employee must present their custody and control receipt before they are allowed back on the jobsite.

FAX THE COMPLETED DOCUMENT FORM (ATTACHED) TO THE DFW OFFICE:
503-742-2415 or email to jdurr@cleanworkforce.com

NORTHWEST IRONWORKERS HEALTH AND SECURITY FUND
DRUG FREE WORKPLACE PROGRAM

POST-ACCIDENT TESTING REPORT

The purpose of this form is to document the purpose, facts and circumstances behind a decision to request a post-accident drug and alcohol test.

EMPLOYEE'S NAME:		DATE:	
EMPLOYEE DOB:		PHONE	
EMPLOYEE LAST 4 OF SSN:			
EMPLOYER:		PHONE	
ACCIDENT LOCATION:		ACCIDENT TIME:	**AM / PM**

NATURE OF THE ACCIDENT:

- ❑ **Accident causing a fatality**
- ❑ **Accident causing an injury requiring off-site medical attention**
- ❑ **Accident causing significant property damage**

Date of Accident: _____

- ❑ **Unsafe activity or near-accident that could have caused:**
- ❑ **Possible death**
- ❑ **Possible injury**
- ❑ **Possible property damage**

Comments (Describe the events/accident and reason for requesting testing, including observed facts and circumstances, any sources of information, date and time of observation or accident, other witnesses, actions taken, etc.):

_____

_____

_____

_____

_____

_____

Requester's Printed Name & Signature | Title | Date

Reviewer's Printed Name & Signature | Title | Date

I acknowledge that I have been informed of the company's reasons for requesting this drug and alcohol test and consent to the testing. Signing this form does not necessarily signify agreement with the above statements.

Employee's Signature: _____ Date: _____

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503-742-2415 or email to jdurr@cleanworkforce.com