

VEHICLE ACCIDENT REPORT



Vehicle and Equipment Accident/Damages

This form, or an approved alternate form, must be completed for all accidents involving any City vehicle, equipment (any item attached to a City Vehicle) or property damage caused by a City vehicle or equipment. Please report any incident immediately and complete all related sections of this report and provide a copy of Fleet Maintenance within one (1) business day for processing (pictures of the damages will be required at the time of incident)

Employee Injuries

Supervisors must be notified immediately by the employee and the incident should be reported to Human Resources immediately or within one (1) business day of the incident.

Note

This form must be signed by the employee involved and the employee's supervisor however, if signatures cannot be obtained within one (1) business day, the form should be forwarded to Fleet Maintenance as soon as possible.

SECTION A – GENERAL INFORMATION

Employee Name: _____ Home Phone#: _____

Home Address: _____
Street Number Street Name City State Zip Country

Job Title: _____ Department: _____

Date of Occurrence: _____ Time of Occurrence: _____ am _____ pm Date reported: _____

Address/Location of Occurrence: _____

Briefly describe accident and how or why it occurred:

Witness' Name (include address if not a city employee):

Was drug test given? Yes No If not, state reason: _____

SECTION B – CITY VEHICLE ACCIDENT OR DAMAGE

City Vehicle #: _____ City Vehicle License #: _____

Was City Vehicle Damaged? Yes No

Make and Model: _____ Year: _____ VIN#: _____

Was there a Police investigation? Yes No If yes, list investigating agency: _____

If yes, report number: _____

Weather Conditions: _____ Road Conditions: _____

Description of Damage: _____

List all passengers in vehicle (*attach additional pages, if necessary*):

Name (First and Last)	Age
_____	_____
_____	_____
_____	_____

SECTION C – OTHER VEHICLE ACCIDENT OR DAMAGE

Was other vehicle damaged? Yes No

License Number: _____ Year: _____ Make and Model: _____

Vehicle Identification Number: _____

Driver's Name: _____

Address: _____

Street Number Street Name City State Zip Country

Phone Number: _____

Insurance Company: _____

Policy Number: _____ Insurance Agent's Phone Number: _____

Weather Conditions: _____ Road Conditions: _____

Description of Damage: _____

List all passengers in vehicle (*attach additional pages, if necessary*):

Name (First and Last)	Age
_____	_____
_____	_____
_____	_____

SECTION D – DAMAGE TO PROPERTY **City Owned?** Yes No

Type of Property Damaged: _____ Phone Number: _____
Owner's Name: _____

Address: _____
Street Number Street Name City State Zip Country

Description of Damage: _____

SECTION E – INJURY TO MEMBER OF THE PUBLIC

Name of Injured: _____

Address: _____
Street Number Street Name City State Zip Country

Phone Number: _____

Nature of and Part of Body Injured: _____

Ambulance Needed? Yes No Hospital: _____ Doctor: _____

SECTION F – PREVENTABLE AND/OR VIOLATION OF POLICY

Preventable – was the accident preventable? Yes No

Policy Violation – was a City or Departmental Policy Yes No

COMMENTS

SIGNATURES

Employee Printed Name: _____ Date: _____

Employee's Signature: _____

Supervisor's Printed Name: _____ Date: _____

Supervisor's Signature: _____