



Accident/Incident Report

Type of Claim Reporting - Check all that apply and complete only the sections applicable.

- | | | |
|---|--|--|
| <input type="checkbox"/> Injury to Employee | <input type="checkbox"/> Automobile Accident-City | <input type="checkbox"/> Damage to City Property-Non Auto |
| <input type="checkbox"/> Injury to Other | <input type="checkbox"/> Automobile Accident-Other | <input type="checkbox"/> Damage to Other Property-Non Auto |

Accident / Incident Information

Date of Incident _____ Time of Incident _____ ☐ a.m. ☐ p.m.

Location of Incident _____

Were there any witnesses? ☐ Yes ☐ No

Name and Address of Witness _____

Incident Description _____

Police Investigation Report # _____ Agency _____

Employee Information

Employee Name _____ Date of Hire _____ Date of Birth _____

Job Title _____ Department/Division _____

Days Worked Per Week _____ Hours Per Week _____ Hourly Rate of Pay \$ _____

Mailing Address _____

Home or Cell Number _____ Work Number _____

Driver License # _____ Expiration Date _____

Was seat belt worn at time of accident? ☐ Yes ☐ No ☐ N/A

Was first aid or doctor visit required? ☐ Yes ☐ No Taken by Ambulance? ☐ Yes ☐ No

Hospital/Medical Facility, if applicable _____

Describe injuries and if employee will lose time from work _____

City Information: Vehicle / Property

Were any motor vehicles involved? ☐ Yes ☐ No If yes, please provide:

City Vehicle # _____ Tag # _____ VIN # _____

Year/Make/Model _____

City vehicles MUST be taken to Fleet Maintenance for appraisal of damages.

Property Damage Description, please provide as much information as possible

Public / Claimant Information

Name _____ Date of Birth _____

Mailing Address _____

Home or Cell Number _____ Work Number _____

Driver License # _____ Expiration Date _____

Was seat belt worn at time of accident? ☐ Yes ☐ No ☐ N/A

Was first aid or doctor visit required? ☐ Yes ☐ No Taken by Ambulance? ☐ Yes ☐ No

Hospital/Medical Facility, if applicable _____

Describe injuries _____

Were any motor vehicles involved? ☐ Yes ☐ No If yes, please provide:

Year/Make/Model _____

Tag # _____ State _____ VIN # _____

Insurance Company _____ Policy # _____

Non-vehicle Damage to Public / Claimant Property

Property Damage Description, describe what happened and provide as much information as possible:

Report completed by: _____ E-Mail Address: _____

Employee Signature: _____ Date: _____

Review & Determination (Employee Incidents Only)

Accident/Injury/Incident Was: ☐ Preventable ☐ Non-Preventable

Disciplinary Action Required: ☐ Yes ☐ No

Action Taken & When: _____

Division Director Signature: _____ Date: _____

Department Director Signature: _____ Date: _____