(Insert City Name)

Supervisor/Employee Incident Investigation Form
Auto Liability, and Vehicle Collision Claim

Date of Accident:_____ **Time of Accident:**_____ **A.M. / P.M.** **City Vehicle # :**_____

Address/Location of Incident:_____

Employee Involved (Driver):_____ **CDL Holder: Yes / No**

Employee Position:_____ **How Long in Position: Yrs.** _____ **Mo.**_____

Department:_____ **Vehicle VIN#:**_____

Employee Complete The Following:

Describe How Accident Occurred:_____

_____

_____

_____

_____

List Cause of Accident:_____

_____

Do You Feel You Did Everything Within Reason To Prevent This Accident? Yes / No (circle).

Explain:_____

_____

_____

_____

What Can be Done to Prevent Similar Future Occurrences?_____

_____

_____

_____

Provide your opinion for the estimated Total Cost of this Accident: $_____

Provide your opinion for the estimated cost for repair/replacement of City Property: $ _____

APPENDIX A

Accident First Reported To:_____ **Date Reported:**_____

Name **Position**

Were Police Present at the Scene of the Accident to Obtain a Report? Yes / No (circle)

Seat Belt In Use at Time of Accident: Yes/No (circle)

Were You Injured as a Result of Accident? Yes / No (circle)

If Yes, Describe Injury Type (strain, fracture, bruise, etc.): _____ **Body Part Affected :**_____

Was anyone else injured as a result of this accident? Yes / No If Yes, provide name and address below:

Name: _____ **Address:** _____ **Phone:** _____

Employee Signature:_____ **Date:** _____

Auto Liability, and Vehicle Collision

Supervisor Complete The Following:

Supervisor's Account of Accident:_____

_____

_____

_____

_____

_____

Do you feel the employee did everything within reason to prevent the accident? Yes / No

Explain Answer:_____

_____

_____

_____

_____

What immediate action was taken to prevent other occurrences?_____

_____

Was Employee Injured as a result of the Accident? Yes / No (circle)

If Yes, Complete the Employee/Supervisor's Injury/Incident Investigation Form

_____ _____

Supervisor's Signature **Supervisor's Name (Print)** **Date**

Department Head Comments:

_____

_____

_____

_____

_____

_____

_____ _____

Department Head Name (Print) **Department Head Signature** **Date**

Witness' Statement (City Employees Only)

Describe in detail what you saw:_____

_____

_____

_____

_____

What was your location in relation to the accident (ex: 5-6’away,etc.)?:_____

What was the apparent cause of the accident?:_____

_____

_____

_____ _____

_____ **Witness Name (Print)** **Witness Signature**

Date

(Form to be Returned to the Legal Department within 48-hours of Incident/Accident)