VEHICLE ACCIDENT INFORMATION FORM (COMPLETE AND RETURN FORM TO RISK MANAGEMENT)

Date of accident: ____________________ Accident time: ___________________________________

Driver's name, title, phone extension:

____

Vehicle occupants: ____

Fleet vehicle #: ___________________ Tag#: _______________

Year/Make/Model: ____

Accident location: ____

Road conditions: _________________________ Weather conditions: _____________________________

Responding police authority: ____

Description of any injuries:

____

____

Workers' compensation Notice of Injury Completed: ( ) Yes ( ) No ( ) N/A: No Injuries

Fleet vehicle speed at time of accident: _________ Damage to fleet vehicle: ________________________

General description of accident: ____

____

____

____

Who was cited for accident? : ____

Vehicle 2 description: ____

Vehicle 2 damage: ____

Driver 2 injury: ____ Vehicle 2 no. of occupants: __________

Description of other property damage, if any: ____

____

Employee printed name and signature: ____

Supervisor printed name and signature: ____