



# Vehicle Accident Report

(Accident involving agency vehicle. May involve bodily injury/property damage.)

Attorney/Client Privileged Document

Form

02

1	Agency name	Today's date		
2	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm, a.m./p.m.)		
3	Name of person completing the report	Title of person completing report		
4	Business phone	Business email		
5	How did the incident occur? (Provide a brief factual summary.)			
6	Name of the location (street/road/highway) or nearest intersection where the incident occurred.			
7	Is there an address for incident location? If yes, please provide the following:			
Street address				
City		State		Zip code
8	Location			
Offsite (non-agency owned) [ ]		On agency property [ ]		
9	Primary location			
Highway/roadway [ ]		Parking lot [ ]		Other [ ]
10	Was the agency vehicle occupied? [ ] Yes [ ] No [ ] Unknown			
11	Agency driver last name			First name
Address				
City		State		Zip code
Home phone #		Work phone #		Cell phone #
Email				
Is this driver an employee? [ ] Yes [ ] No [ ] Unknown				
If Yes, enter job title of employee				
Identify the type of driver				
Full-time employee [ ]		Intern [ ]		Non-agency employee [ ]
Part-time employee [ ]		Volunteer [ ]		Spouse/family member [ ]
Seasonal employee [ ]				
12	Agency vehicle VIN	Make	Model	License number

**13** Is vehicle drivable?  Yes  No  Unknown  
If no, provide current location of vehicle

**14** Area of damage

**15** Estimated repair cost

**16** Was a trailer involved?  Yes  No  Unknown  
If yes, provide the following information.

Trailer year	Make	Model	License number

Trailer area of damage

Current location of trailer

Estimated repair cost of trailer

**17** Has a police agency conducted an investigation?  Yes  No If yes, provide the following information.  
What police agency investigated the incident?  
Police report number

**18** Was the agency driver ticketed, arrested or cited for violation(s)?  Yes  No  Unknown  
If yes, provide details of the ticket, arrest or violation(s).

**19 CLAIMANT INFORMATION**

Identify other people involved in the accident. *(Make additional copies of this section if needed.)*  
How was the person involved in the accident? *(Check all that apply.)*

Driver of other vehicle <input type="checkbox"/>	Injured person <input type="checkbox"/>	Owner of involved property <input type="checkbox"/>
Owner of other vehicle <input type="checkbox"/>	Passenger of agency vehicle <input type="checkbox"/>	Passenger of other vehicle <input type="checkbox"/>
Pedestrian <input type="checkbox"/>		

Last name or business name First name (not necessary for business)

Address

City State Zip code

Home phone # Work phone # Cell phone #



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<b>19</b>	Vehicle make	Model	Year
Area of damage			
Is vehicle driveable? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, current location of vehicle			
Extent of damage <input type="checkbox"/> Moderate <input type="checkbox"/> Nothing visible <input type="checkbox"/> Severe <input type="checkbox"/> Slight			
Describe the property damage ( <i>other than vehicle</i> )			
Extent of damage to property other than vehicle <input type="checkbox"/> Moderate <input type="checkbox"/> Nothing visible <input type="checkbox"/> Severe <input type="checkbox"/> Slight			
Age of injured person _____		Sex of injured person	<input type="checkbox"/> Male <input type="checkbox"/> Female
Was the injured person transported by paramedics? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, where was the injured person taken?			
Do you expect the injured person to file a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe the injury			

## ADDITIONAL CLAIMANT INFORMATION

Identify other people involved in the accident. (*Make additional copies of this section if needed.*)

How was the person involved in the accident? (*Check all that apply.*)

Driver of other vehicle	<input type="checkbox"/>	Injured person	<input type="checkbox"/>	Owner of involved property	<input type="checkbox"/>
Owner of other vehicle	<input type="checkbox"/>	Passenger of agency vehicle	<input type="checkbox"/>	Passenger of other vehicle	<input type="checkbox"/>
Pedestrian	<input type="checkbox"/>				

Last name or business name

First name (not necessary for business)

Address

City

State

Zip code

Home phone #

Work phone #

Cell phone #

Vehicle make

Model

Year

Area of damage

Is vehicle driveable?     Yes     No    If no, current location of vehicle

Extent of damage     Moderate     Nothing visible     Severe     Slight

Describe the property damage (*other than vehicle*)

Extent of damage to property other than vehicle     Moderate     Nothing visible     Severe     Slight

<b>19</b>	Age of injured person _____	Sex of injured person	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	Was the injured person transported by paramedics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, where was the injured person taken?			
	Do you expect the injured person to file a claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Describe the injury			
<b>20</b>	Identify witnesses of the accident. (Provide the following information for each witness. Make additional copies of this page if needed.)			
	Last name		First name	
	Address			
	City	State	Zip code	
	Home phone #	Work phone #	Cell phone #	
	Witness to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, provide the following information.			
	Relation to injured person or property owner:			
	Agency employee or volunteer <input type="checkbox"/>	Another program participant or park user <input type="checkbox"/>	Friend <input type="checkbox"/>	
	Other <input type="checkbox"/>	Passerby <input type="checkbox"/>	Relative <input type="checkbox"/>	
	Did witness make any statements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	If yes, provide the following information.			
	What did witness say?			
	Where was witness when the accident occurred?			
<b>21</b>	Was the driver of the agency vehicle conducting agency business at the time of the accident?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>22</b>	What street was the agency driver on?		What street was the other driver driving on?	
<b>23</b>	What direction was the agency driver traveling?		<input type="checkbox"/> North	<input type="checkbox"/> South
			<input type="checkbox"/> East	<input type="checkbox"/> West
	What direction was the other driver traveling?		<input type="checkbox"/> North	<input type="checkbox"/> South
			<input type="checkbox"/> East	<input type="checkbox"/> West
<b>24</b>	Weather conditions			
	Dry <input type="checkbox"/>	Fog <input type="checkbox"/>	Ice <input type="checkbox"/>	Snow <input type="checkbox"/>
				Wet <input type="checkbox"/>
<b>25</b>	Accident diagram			