JEFFERSON COUNTY
VEHICLE ACCIDENT REPORT

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO HUMAN RESOURCES WITHIN 24 HOURS FROM THE TIME OF THE ACCIDENT.

Employee Name: ________________________________Department: __________________________

Job Title: _______________________________________Vehicle: _____________________________

Date of Accident/Incident: ____________________ Time of Accident/Incident: ___________________

Date Reported: ____________________ To Whom Reported: _________________________________

Supervisor: _____________________________________

Accident /Incident Location: ____

801 Claim Form Filed? Y ( ) N ( )
Complete if medical treatment sought or time lost from work

OTHER VEHICLE /DRIVER INFORMATION

Name: ____________________________________ Phone Number: ___________________________

____
Street City State Zip

Driver's License Number: _______________________________________ State: _____________

Passenger Information: ____
Name Address City State Zip

Phone Number: ____

Second Passenger: ____
Name Address City State Zip

Phone Number: ____

Vehicle Information: Year: _________ Make: ____________________ Model: ___________________

Registered Owner: _______________________________________ Phone: ____________________

Insurance Co. of Other Vehicle: __________________________ Policy Number: _________________

Insurance Co. Phone Number: ________________________ Ext: __________

Once completed please submit to the Finance Department.

Witness(es):

____
NAME PHONE NUMBER ADDRESS

____
NAME PHONE NUMBER ADDRESS

____
NAME PHONE NUMBER ADDRESS

Describe what happened (include sequence of events; weather, road conditions, etc.) (PLEASE BE SPECIFIC):____
____
____
____

Damage to other vehicle:
____

____

Damage to County Vehicle: ____

____

To Be Completed by Employee's Supervisor:

Why did the accident/incident happen or the condition exist?
____
____

What could have been done, or should be done, to prevent this accident/incident?
____
____

Have there been accidents or incidents in resulting from same activity?
____
____

Employee's Signature: ______________________________ Date: ____________

Supervisor's Signature: _____________________________ Date: ______________

Risk Manager's Signature: __________________________ Date: ______________

Once completed please submit to the Finance Department.