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| **COUNTY OF EL PASO****Vehicle Traffic Accident Report Form** |
| Page 1 of 3**PART I****(TO BE FILLED OUT BY THE INVOLVED EMPLOYEE)****ALL TRAFFIC ACCIDENTS SHALL BE REPORTED WITHIN 48 HOURS TO** **HUMAN RESOURCES DEPARTMENT –RISK MANAGEMENT DIVISION**  |
| Employee Name: |   | D.O.B. |   | DL#: |   |
|  Date of Hire  |   | Employee Home Address: |   |
| Job Title: |   | Department: |   |
| Time Shift Began: |   | Week Day: |   | Date of Accident |   | Time of Accident: |   |
| Location of Accident: |  Make:Model:VIN# (last 4): |
| Vehicle Information: | Year: |   | Make: |   | Model: |   | VIN# (last 4): |   |

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| **Describe details of the accident. Include direction of travel, speed, time, weather conditions and any other factors contributing to the accident. (Please use Page 3 if more space is required)** |
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| **Medical Information:** |  |
| Did you receive any medical treatment? | [ ]  Yes | [ ]  No |  |
| If medical attention was required, give the treatment received and the doctor’s name and instructions: |
|   |
| **In your opinion, what contributed to the Incident?** |
| [ ]  Unsafe Procedure | [ ]  Defective Equipment | [ ]  Excessive Speed |
| [ ]  Unsafe Practice | [ ]  Improper Equipment | [ ]  Failed to yield right of way |
| [ ]  Unauthorized Use | [ ]  Driver Inattention | [ ]  Other vehicle failed to observe traffic devices |
| [ ]  Horseplay | [ ]  Lack of Knowledge/Skill | [ ]  Other: \*(complete below) |
| [ ]  Vehicle Maintenance | [ ]  Road Defects |  |
| \* Explain “Other” selection |  |
| How would you prevent a recurrence of the same or similar accident? (Use Page 3 if more space is required) |
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| Employee’s Printed Name |  | Title |
|   |  |   |
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| Employee’s Signature |  | Date |
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|  SUPERVISOR REVIEW OF TRAFFIC ACCIDENT (Supervisor review must be completed and forwarded to the Human Resources Department within five (5) working days of the accident.) |
|  PART II Page 2 of 3 |
| NATURE OF INCIDENT (check all that apply) | Date you were notified of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
| [ ]  On the job injury \*submit Occupational Injury report form [ ]  County Vehicle/Equipment Damage[ ]  No Damage  | [ ]  Other party injury (complaint or visible)[ ]  Other party Vehicle/Equipment Damage[ ]  Law Enforcement notified  |
| Summarize the Incident based on your review. Where and how it happened, identify any vehicles or equipment involved, and attach any drawings, diagrams, photographs, or police reports if necessary to further explain. If same as employee section put “same as noted above”. (Use Page 3 if more space is required) |
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| Explain “Contributing Factors to the Incident” (identify any unsafe ACT and/or CONDITION which may have contributed to the Incident) |
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| Explain “Corrective Measures” you are taking to prevent a similar or repeat incident: |
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| **Other Vehicles Involved:** |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Year: |   | Make: |   | Model: |   | Color: |   |
| Driver’s Full Name: |   | Address: |   |
| Home Phone: |   | Insurance Carrier: |   | Policy #: |   |

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| **Private Property Damage:** | Address: |   |
| Owner’s Full Name: |  . | Phone Number: |   |  |
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| **Describe Damage: (Use Page 3 if more space is required)** |
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| Printed Name of Supervisor |  | Title |
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| Signature of Supervisor |  | Date |
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| **Use this space to provide any additional information (Optional)**Page 3 of 3 |
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Revised: 08/17/12