

Vehicle Accident/Incident Report

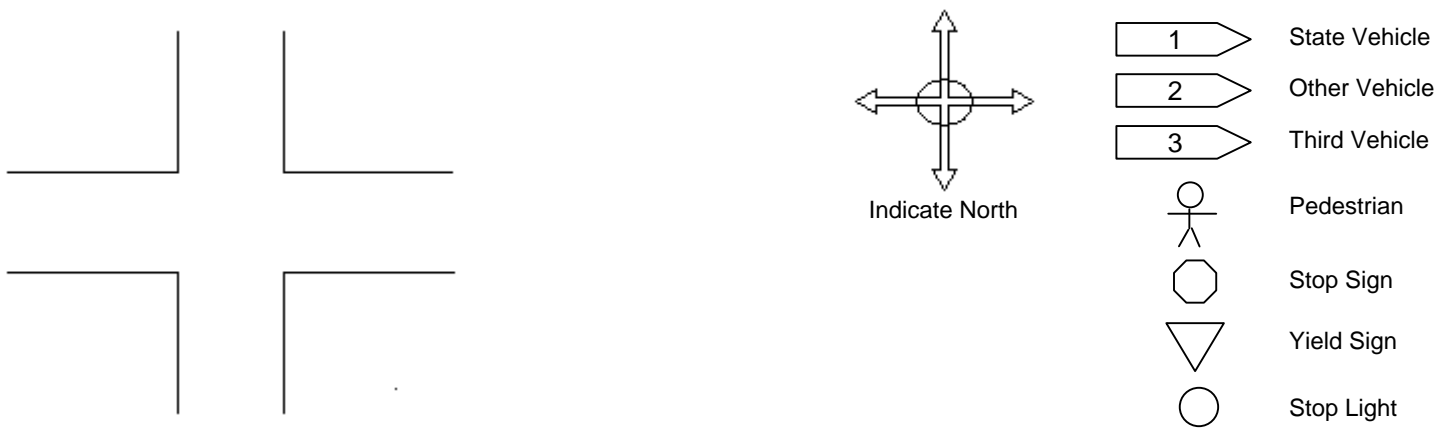
Instructions: In case of an accident involving a state-owned vehicle, the driver of the vehicle must:

1. Report the accident promptly to a local law enforcement agency and obtain a copy of the officer's report.
2. Contact your supervisor and fleet manager as soon as practical to report the accident.
3. Within 24 hours of the accident, submit this completed & signed form to your supervisor.
4. Submit this completed form, signed by your supervisor, to the appropriate Fleet Office within 48 hours.
5. If the police do not respond or complete the accident report and the accident has caused bodily injury, vehicle property damage is \$1,000 or more and/or government-owned property damage is \$200 or more the driver must submit a completed MV-4002 Driver's Report of Accident to the Department of Transportation within ten days. Forward a copy to the fleet office.

Agency/Dept. Location	Agency/Department Name		Division/Institution/Campus		Agency Number	
	Supervisor's Name			Phone Number ()		
	Street Address		City	ZIP + 4		
Location of the Accident	Street/Highway				Accident Date (mm/dd/ccyy)	
	City	County	State	Accident Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	
State Vehicle Information	State Vehicle Owner Agency/Dept. Name		Reason for Vehicle Use			
	Year	Make/Model	Body Type	Mileage	Color	
	Fleet Number	Vehicle Identification Number		License Plate Number		
	Describe Parts Damaged		Circle numbered areas of vehicle damage.			
<input type="checkbox"/> Assigned <input type="checkbox"/> Pool/ Functional						
Information on Driver of State Vehicle	Driver Name	<input type="checkbox"/> Driver Injured <input type="checkbox"/> Wearing Seat Belt	Home Phone ()	Work Phone ()		
	Email Address	Date of Birth	Driver's License Number			
	Work Address	City	State	ZIP + 4		
	Home Address	City	State	ZIP + 4		
	Were There Passengers in This Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List Names: _____		Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		Wearing Seat Belt <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Party(s) Involved (add additional sheets if more than one other party involved)	(Please indicate what type of property was damaged.) <input type="checkbox"/> automobile <input type="checkbox"/> fence <input type="checkbox"/> building <input type="checkbox"/> guard rail <input type="checkbox"/> other _____	Describe Parts Damaged		If automobile, circle numbered areas of vehicle damage.	
Property Owner (if different from driver)		Home Phone ()	Work Phone ()			
Home Address		City	State	ZIP + 4		
Year		Make/Model	Body Type	License Plate Number		
Vehicle Identification Number		Insurance Company		Phone ()		
Agent Name		Address				
Driver Name		<input type="checkbox"/> Driver Injured <input type="checkbox"/> Wearing Seatbelt	Home Phone ()	Work Phone ()		
Home Address		City	State	ZIP + 4		
Driver's License Number						
Were there passengers in this vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List Names: _____		Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		Wearing Seat Belt <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		

Was the accident investigated by a law enforcement agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were photographs taken at the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	By whom?
Name of the Investigating Officer	Law Enforcement Agency Name	Case Number
Were citations issued? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom?	
Road Conditions <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy <input type="checkbox"/> Other _____	Did the state vehicle have lights on? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Bright <input type="checkbox"/> Dim	Did the other vehicle have lights on? (if other vehicle involved) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Bright <input type="checkbox"/> Dim
At what speed were you (state vehicle) traveling?	At what speed was the other vehicle traveling?	Posted Speed Limit
What traffic controls were in effect?	For whom?	Who had the right of way?
What signals were given by you?		What signals were given by the other driver?
What did you do to avoid the accident?		What did the other driver do to avoid the accident?
Witness Information	Name of Witness	
	Home Address	Phone Number ()
	City	State ZIP + 4
Driver Description of the Accident/Incident <input type="checkbox"/> Attached sheets include additional description, witness and passenger information.		

Please complete this diagram. Indicate names of streets, direction, position of vehicles and point of contact. Use a solid line to show path before the accident and a dotted line to show path after the accident.



As the driver of the state owned vehicle described in this report, I acknowledge that all information provided is true and accurate to the best of my knowledge.

Scope of Employment Statement	
As supervisor of this position, I affirm that the individual named driver was operating the vehicle within his or her authorized scope of employment at the time of the accident. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Driver (<i>Required</i>)	Signature of Supervisor (<i>Required</i>)
Date (mm/dd/ccyy)	Date (mm/dd/ccyy)

Signature of Driver (<i>Required</i>)	Signature of Supervisor (<i>Required</i>)
Date (mm/dd/ccyy)	Date (mm/dd/ccyy)