AUTO ACCIDENT REPORT KIT

I. In Case of Accident

A. Stop and investigate immediately
B. Set out warning devices if available or set vehicle flashers
C. Assist injured persons but do not move if it will cause further injury; call for medical assistance if needed
D. Notify police, supervisor, and Human Resources
E. Give your name, employer's name, and vehicle registration number.
Insurance Carrier: One Beacon Insurance Company/Surry Insurance Agency (336.407.9579)
If your own vehicle is involved you give them your own insurance information.
F. Secure names and addresses of witnesses or first persons at scene (use witness cards)
If you strike an unattended vehicle or personal property and the owner cannot be located/contacted immediately, you must place your name and address of your employer securely on the vehicle/property
G. Protect your vehicle from further damage and theft
H. Comply with required alcohol/drug test
I. If your supervisor or risk manager cannot assist with the investigation return the completed packet to your supervisor immediately.

COMPLETE FOLLOWING FORMS (SUPPLIED INSIDE)

1. Harnett County Vehicle Accident Report
2. Employee Description and Supervisor Investigation Report
3. Witness Cards if Witnesses are Available

Harnett County Vehicle Accident Report
(File this report immediately with your supervisor or the Risk Manager if involved in an accident)

Department _____ County Vehicle No: _____

County Driver: _____

Name: _____ Drivers License # _____ Phone:_____

Was Seat Belt(s) Used? ☐ Yes ☐ No

Accident Data:

Date: _____ Time: _____ ☐ AM ☐ PM

Address/Location/Intersection: _____

Did Law Enforcement Investigate? ☐ Yes ☐ No Agency/Department: _____

Officer Name: _____ Phone Number: _____ Report Number: ____

County Vehicle ☐ Yes ☐ No Personal Vehicle ☐ Yes ☐ No

Make of Vehicle: _____ Year: _____ Model: _____ VIN #: _____

Vehicle Plate #: _____

Describe Damage:

_____

_____

Est Damage $ _____

Drivable: ☐ Yes ☐ No Towed: ☐ Yes ☐ No Where: _____

Other Driver (vehicle 2):

Name: _____ Drivers License #: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Owner : _____ Phone #: _____

Name of Owner's Insurance Company: _____

Agent: _____ Agent Ph#: _____

Make of Vehicle: _____ Year: _____ Model: _____ VIN #: _____

Vehicle Plate #: _____

Describe Damage:

_____

_____

Est Damage $_____

Drivable: ☐ Yes ☐ No Towed: ☐ Yes ☐ No Where: _____

If more than 2 vehicles continue on page 4:

Property Damage – Other Than Auto (Fence, Guardrail, etc.):

Owner: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Describe Property: _____

Location: _____

Witnesses:

Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

If more than 1 witness continue on page 5:

 # Persons Injured: _____
(If a County employee is injured, a Workers' Compensation Packet must be completed with this report.)

Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Which Vehicle? (County, Other Vehicle, Pedestrian) _____

Description of Injuries:

_____

_____

If more injured continue on page 5:

Continued Other Drivers:

Other Driver (vehicle 3)

Name: _____ Drivers License #: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Owner : _____ Phone #: _____

Name of Owner's Insurance Company: _____

Agent: _____ Agent Ph#: _____

Make of Vehicle: _____ Year: _____ Model: _____ VIN #: _____

Vehicle Plate #: _____

Describe Damage:

_____

_____

Est Damage $_____

Drivable: ☐ Yes ☐ No Towed: ☐ Yes ☐ No Where: _____

Other Driver (vehicle 4)

Name: _____ Drivers License #: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Owner : _____ Phone #: _____

Name of Owner's Insurance Company: _____

Agent: _____ Agent Ph#: _____

Make of Vehicle: _____ Year: _____ Model: _____ VIN #: _____

Vehicle Plate #: _____

Describe Damage:

_____

_____

Est Damage $_____

Drivable: ☐ Yes ☐ No Towed: ☐ Yes ☐ No Where: _____

Other Witnesses Continued:

Witnesses:

Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Witnesses:

Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Witnesses:

Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Persons Injured Continued:

Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Which Vehicle? (County, Other Vehicle, Pedestrian) _____

Description of Injuries:

_____

_____

Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Which Vehicle? (County, Other Vehicle, Pedestrian) _____

Description of Injuries:

_____

_____

Employee Description and Supervisor Investigation Report

To be completed by EMPLOYEE:

Name: _____

Department: _____ Shift: ____ Position: _____

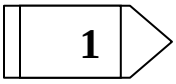
☐ Male ☐ Female

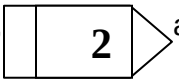
Time of Accident: _____ Date of Accident: _____

Time Accident Reported: _____ Date Reported: _____

Employees Description of Accident:

_____
_____
_____
_____
_____

Draw a diagram of accident using 

as your vehicle, 

as vehicle 2 etc.

The Harnett County Accident Review Board will schedule the facts of this accident for review. The purpose of these reviews is:

A. To establish a fair and impartial review system for all vehicular and non-vehicular accidents involving County employees/citizens, which result in injuries, illnesses and/or property damage. The primary objective is to improve the overall safety of County operations.
B. To establish the cause for each review accident, and determine whether preventable or non-preventable
C. To establish a uniformity of discipline.
D. To make recommendations for corrective action to Department Heads, County Manager and/or the County Board of commissioners.

Employees are allotted the opportunity of making a presentation at the review if they so choose. Employees must notify their supervisor if they wish to attend this hearing.

Supervisor investigation:
Unsafe Act, Condition, or Procedure (Check one or more)
Failure:

- ☐ of other driver
- ☐ mproper lane change
- ☐ to use evasive measures
- ☐ to allow other vehicle to merge
- ☐ improper parking
- ☐ to comply w/operating procedures
- ☐ improper turning
- ☐ to enter intersection properly
- ☐ to yield after stop
- ☐ to obey sign/signals
- ☐ to perform pre-trip inspection
- ☐ to stay on roadway
- ☐ to allow other vehicle to pass
- ☐ improper merge
- ☐ to watch overhead clearance
- ☐ to watch side clearance
- ☐ to watch vehicle alongside
- ☐ insufficient following distance
- ☐ to yield before turn
- ☐ improper backing
- ☐ too fast for conditions
- ☐ to report accident

Other:_____
_____
_____

_____ PREVENTABLE (Employee Failed to Drive Defensively)
_____ UNPREVENTABLE (Employee could not have avoided crash)

Supervisor's Statement:
_____
_____
_____
_____
_____
_____

What action has been or will be taken to prevent a future similar occurrence?_____
_____

Supervisor's signature: _____
Date: _____