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.

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**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 $___________
Auto Accident Report Kit

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 1 as your vehicle, 2 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
☐ improper 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: __________________________