AUTO ACCIDENT REPORT FORM

Date of Loss	
Time of Loss	☐ AM ☐ PM
Exact Location	
Department	
Authority Contacted	
Report # (attach if available)	

Employee Information

Employee Name	
SSN (Last 4 Digits)	
Job Title	
Department/Subdivision	/
Supervisor	
Workers Compensation claim also filed?	☐ Yes ☐ No
If yes, please describe injuries	
Was the employee cited?	☐ Yes ☐ No
If yes, please describe	

Reporting

Person Notified	
Date and Time Notified	/ / : ☐ AM ☐ PM

Description of Loss

Detailed Description of How Loss Occurred	
Year/Make/Model of Vehicle	
Vehicle VIN Number	
License Plate #	
Vehicle Number	
Driver Name	
Estimated Damage	$
Witnesses Names and Phone Numbers	______ ______ ______

Other Claims Filed in Addition to This Claim

Property	☐ Yes ☐ No
Liability	☐ Yes ☐ No
Workers Compensation	☐ Yes ☐ No

Third Party Information

Third Party Cited	☐ Yes ☐ No
Other Driver Name	
Other Driver Address	
Other Driver Phone	
Other Driver Injuries	☐ Yes ☐ No ☐ Unknown
If yes, please describe	
Other Driver Insurance Company Information	
Other Driver Estimated Damage	$
If third party property was damaged, please provide detailed description (owner name, address, description of property that was damaged, estimated damage, etc.)	

Reported by: _____

Comments: _____

Complete this form and submit to Human Resources within 24 hours of the loss.
Complete all fields if the information is available.
Contact Human Resources at 814-6402 with questions.