



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: NCACC Joint Risk Management Pools (877-622-2276)
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



Auto Accident Report Kit

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#: _____



Auto Accident Report Kit

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:



Auto Accident Report Kit

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: _____



Auto Accident Report Kit

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.



Auto Accident Report Kit

Supervisor investigation:

Unsafe Act, Condition, or Procedure (Check one or more)

Failure:

- | | |
|---|--|
| <input type="checkbox"/> of other driver | <input type="checkbox"/> to stay on roadway |
| <input type="checkbox"/> improper lane change | <input type="checkbox"/> to allow other vehicle to pass |
| <input type="checkbox"/> to use evasive measures | <input type="checkbox"/> improper merge |
| <input type="checkbox"/> to allow other vehicle to merge | <input type="checkbox"/> to watch overhead clearance |
| <input type="checkbox"/> improper parking | <input type="checkbox"/> to watch side clearance |
| <input type="checkbox"/> to comply w/operating procedures | <input type="checkbox"/> to watch vehicle alongside |
| <input type="checkbox"/> improper turning | <input type="checkbox"/> insufficient following distance |
| <input type="checkbox"/> to enter intersection properly | <input type="checkbox"/> to yield before turn |
| <input type="checkbox"/> to yield after stop | <input type="checkbox"/> improper backing |
| <input type="checkbox"/> to obey sign/signals | <input type="checkbox"/> too fast for conditions |
| <input type="checkbox"/> to perform pre-trip inspection | <input type="checkbox"/> 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: _____