



Motor Vehicle Accident Report

City Of Clarksville

Department		Accident Date	Accident Time	Report Date	Report Time	Name of Immediate Supervisor
Occupation		Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Other:				
EMPLOYEE	Name		Date of Birth	Age	Home Phone (931) -	Work Phone (931) -
	Home Address		City	State	Zip	
	Equipment Used at Time of Accident <input type="checkbox"/> Seat Belt <input type="checkbox"/> Other					
SIGN	I understand and agree the information contained on this form is true and correct to the best of my ability.					
	Employee Signature:				Date:	

FOLLOWING SECTIONS TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

ACCIDENT INFORMATION	Accident Location (street address or nearest street)					City Property <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe What Happened				Collision Type	Contributing Factors By City Driver <input type="checkbox"/> Unavoidable <input type="checkbox"/> Preventable	
					Vehicle Make	Model	Year
	Sketch Accident Scene Below				Damage to City Vehicle <input type="checkbox"/> Over \$1,000 <input type="checkbox"/> Vehicle Towed from Scene		
					Name of Other Driver		
					Address of Other Driver		
					City	State	Zip Code
					Home Phone Number () -	Work Phone Number () -	
					Other Driver's Vehicle (Year, Make, Model)		
					Other Driver's License (Number and State)		
				Witness Name			
				Home Phone Number () -	Work Phone Number () -		

SUPERVISOR'S INFO	Was Employee Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was DOT Drug/Alcohol Screening Done? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Safety Coordinator or HR Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
	What Steps Are Being Taken To Prevent A Similar Accident?		
	Did Accident Involve a Fatality or Hospitalization of 3 or More Employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Anyone in Accident Treated Medically Away from Accident Scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Weather at Time of Accident		Was Employee Trained to Operate Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Accident Reported To Police? <input type="checkbox"/> Yes (attach copy) <input type="checkbox"/> No

REVIEW	Report Prepared By	Signature	Date
	Supervisor Reviewing Report	Signature	Date
	Department Head	Signature	Date
	Date Received by Risk Management	Follow Up Required <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Action