

City of Hickory Vehicle/Equipment Accident or Property Damage Form
To be completed by Coworker Only

****Submit this Report within 24 Hours of Accident/Incident and Return to Supervisor****

Date of Accident: _____ Time of Accident: _____

Address of Accident: _____

Last Name: _____ First Name: _____ MI: _____

Department: _____ Position Title: _____

Immediate Supervisor: _____ Supervisor Notified: _____

Date and Time Supervisor Notified: _____ Witnesses: _____

Drug Test?: Yes ___ No ___ Responding Law Enforcement Agency: _____

VIN of City Vehicle: _____ VIN of Other Vehicle: _____

Serial # ETC of Equipment: _____ Other Property Damage: _____

Description of Accident (when no injury):

Property Damage:
Property Owner Name: _____
Address: _____
Number: _____
Description of Damages/Stolen Property:

Additional Comments:

I certify that my statements made in this report are true, complete and correct to the best of my knowledge and belief and are made in good faith. I authorize investigation of all statements made in this report. I understand that false information may be grounds for dismissal.

Coworker Signature: _____ Date: _____

City of Hickory Vehicle/Equipment Accident or Property Damage Form
Supervisor Investigation Form

****Submit this Report within 24 Hours of Accident/Incident to Risk/Human Resources****

Did Coworker Return to Work? ____ Yes ____ No If so, Date and Time Returned: _____

Time Coworker Began Work: _____ Number of Hours Scheduled to Worked: _____

Who was responsible for the job site?: _____

Was the coworker interviewed regarding the accident/incident? ____ Yes ____ No

If so, when were they interviewed?: _____

What Personal Protective Equipment or Safety Equipment Was Being Used?	
<input type="checkbox"/> Safety Glasses	<input type="checkbox"/> Hard Hat
<input type="checkbox"/> Respirator/Mask	<input type="checkbox"/> Gloves
<input type="checkbox"/> Hearing Protection	<input type="checkbox"/> Flagging/Signage/Barricades in Place
<input type="checkbox"/> Safety Boots/Shoes	<input type="checkbox"/> Chaps
<input type="checkbox"/> Safety Vest	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Gas Detector	
<input type="checkbox"/> Seat Belt	

Was Equipment Used Correctly?
<input type="checkbox"/> Yes
<input type="checkbox"/> No

How could this accident/incident been avoided? What, if any, changes will be made?:

Was this corrective action made aware to the coworker? ____ Yes ____ No

Was disciplinary action taken? ____ Yes ____ No If not, please explain: _____

Other Comments or Information: _____

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Supervisor Signature: _____ Date: _____