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: _____ Reset

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: _____

Reset

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?

☑ Safety Glasses	☐ Hard Hat	Was Equipment Used Correctly?
☑ Respirator/Mask	☐ Gloves	
☑ Hearing Protection	☐ Flagging/Signage/Barricades in Place	☑ Yes
☐ Safety Boots/Shoes	☐ Chaps	☐ No
☐ Safety Vest	☐ Other (specify) _____	
☐ Gas Detector		
☐ Seat Belt		

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:

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.

Supervisor Signature: _____ Date: _____

Department Head Signature: _____ Date: _____