

## Fleet Driver Report of Accident/Incident/Event

Accident/Incident Date:			Accident/Incident Time:		
Report Type: Accident	<input type="checkbox"/>	Incident	<input type="checkbox"/>	Event	<input type="checkbox"/>
Report Type: Initial			<input type="checkbox"/>	Interim	<input type="checkbox"/>
			<input type="checkbox"/>	Final	<input type="checkbox"/>

### Spending Unit Driver Information (You may complete this section at your office)

Name:		Date of Birth:			
Job Title:		Assigned Department/Division:		Work Phone Number:	
Driver's License Number:	Expiration Date:		Date Last Completed Defensive Driver Training?		Seat Belt On?
					<input type="checkbox"/> Yes <input type="checkbox"/> No

### Spending Unit Vehicle Information (You may complete this section at your office)

Vehicle Make:		Vehicle Model:		Vehicle Number:	
Vehicle License Plate Number:		Vehicle Color:		Odometer at time of accident / incident:	
Describe Damages to Spending Unit Vehicle:		<input type="checkbox"/> Minor		<input type="checkbox"/> Moderate	
				<input type="checkbox"/> Major	
Is this a rental vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this a Personally Owned Vehicle?		<input type="checkbox"/> Yes
					<input type="checkbox"/> No
	If YES, provide name of rental company				

### Accident Details (to be completed at the scene of accident/incident)

Location of Accident/Incident	Address:		City:		State:		Zip Code:	
Road Conditions:	Dry <input type="checkbox"/>	Wet <input type="checkbox"/>	Ice <input type="checkbox"/>	Snow <input type="checkbox"/>	Weather Conditions:		Overcast <input type="checkbox"/>	Rain <input type="checkbox"/>
							Snow <input type="checkbox"/>	Fog <input type="checkbox"/>
Traffic Conditions:	Light <input type="checkbox"/>	Heavy <input type="checkbox"/>	How fast were you driving - MPH?		Estimated speed of other vehicle:			

### Other Driver / Registered Owner / Vehicle Information (To be completed at the scene of accident/incident)

Driver's Name:		Date of Birth:		Driver's License No.:	State:	Expiration Date:	
Home Phone Number:		Work Phone Number:			Number of Passengers in Other Vehicle:		
Driver's Address	Street:		City:		State:		Zip Code:
Registered Owner of Other Vehicle (If different from Driver)		Home Phone Number:			Work Phone Number:		
Owner's Address	Street:		City:		State:		Zip Code:
Other Party's Insurance Info	Insurance Co:		Address:		Phone Number:		Policy Number:
Vehicle Make:	Vehicle Model:	Year:		Color:			
Extent of Damages to Other Vehicle:	<input type="checkbox"/> Minor		<input type="checkbox"/> Moderate		<input type="checkbox"/> Major		
License Plate of Other Vehicle	Plate Number:		State:		Describe Damages to Other Vehicle:		

### WITNESSES (To be completed at the scene of accident/incident)

Name	Address		Phone Number	
Name	Address		Phone Number	
Name	Address		Phone Number	

Passengers in Spending Unit Vehicle (You may complete this section at your office)			
Name:	Address:	Phone Number:	Describe Injury (If Applicable)
Name:	Address:	Phone Number:	Describe Injury (If Applicable)

Passengers in Other Vehicle (To be completed at the scene of accident/incident)			
Name:	Address:	Phone Number:	Describe Injury (If Applicable)
Name:	Address:	Phone Number:	Describe Injury (If Applicable)

Describe How This Accident/Incident Occurred

Was There Any Additional, Non-Vehicle Property Damage?

Check & Name Agencies Responding to the Accident/Incident Scene					
<input type="checkbox"/> Fire	<input type="checkbox"/> Ambulance	<input type="checkbox"/> State Police	<input type="checkbox"/> City Police	<input type="checkbox"/> County Sheriff	<input type="checkbox"/> Other
Was a Report Made?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Accident Report Number:		
Investigating Agency:	Name			Address	
Date & Time 911 was Notified of Accident/Incident	Date:		Time:		

Signature of Spending Unit Driver

Date

To Be Completed by Spending Unit Driver Supervisor			
Supervisor's Name:		Phone Number:	
In Your Opinion, Could This Accident/Incident Have Been Prevented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, explain:
Recommendations:			

Signature of Supervisor

Date