


VEHICLE ACCIDENT OR DAMAGE REPORT

IMPORTANT INSTRUCTIONS

This form must be completed for all damage or injury involving county vehicles within 24 hours. Enter the information into STARSWeb. Place the STARS claim number on the top right hand corner of page two. FAX the entire report to Risk Management at (410) 222-7640. Forward the original form to Risk Management at MS 9303.

PLEASE PRINT OR TYPE

Anne Arundel County, MD

SECTION 1 COUNTY VEHICLE #1	EMPLOYEE'S FIRST NAME MIDDLE LAST NAME			JOB TITLE		DATE OF BIRTH		HOME PHONE				
	EMPLOYEE'S STREET ADDRESS			CITY		STATE		ZIP		WORK PHONE	EXT	
	DEPT/SUB-DEPT/SECTION IDENTIFICATION				DEPT CODE		COUNTY VEHICLE NUMBER		TAG NUMBER			
	DRIVER LICENSE NUMBER			CLASS	EXPIRES	STATE		SOCIAL SECURITY NUMBER				
	IS VEHICLE DRIVABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No		DRIVEN FROM SCENE? <input type="checkbox"/> Yes <input type="checkbox"/> No		INVESTIGATED BY: <input type="checkbox"/> County <input type="checkbox"/> State or <input type="checkbox"/> City Police			REPORT NUMBER				
	VEHICLE MAKE			VEHICLE MODEL			YEAR		WERE SEATBELTS BEING WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	DESCRIPTION OF VEHICLE DAMAGE (Extent and Location)				WAS DRIVER INJURED? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:							
	ON DUTY? <input type="checkbox"/> Yes <input type="checkbox"/> No			RESPONDING TO EMERGENCY? <input type="checkbox"/> Yes <input type="checkbox"/> No			WERE LIGHTS & SIREN ACTIVATED? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	PASSENGERS IN COUNTY VEHICLE	NAME(S) OF PASSENGERS		PHONE	ADDRESS			INJURIES		AGE		
SECTION 2 OTHER VEHICLE #2	VEHICLE MAKE		YEAR	TAG NUMBER		IS VEHICLE DRIVABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No		DRIVEN FROM SCENE? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	NAME OF DRIVER		STREET ADDRESS			CITY		STATE	ZIP	PHONE NUMBER		
	NAME OF OWNER		STREET ADDRESS			CITY		STATE	ZIP	PHONE NUMBER		
	DESCRIPTION OF VEHICLE DAMAGE (Extent and Location)				WAS DRIVER INJURED? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:							
	PASSENGERS IN OTHER VEHICLE	NAME(S) OF PASSENGERS		PHONE	ADDRESS			INJURIES		AGE		
INSURANCE COMPANY NAME			AGENT'S NAME		AGENT'S PHONE NUMBER		INSURANCE POLICY NUMBER					
SECTION 3	3 OR MORE VEHICLES		Complete Section 2 on additional Vehicle Accident or Damage Report Forms									
	DAMAGE TO PROPERTY OTHER THAN AUTO		NAME OF OWNER		STREET ADDRESS			CITY		STATE	ZIP	PHONE NUMBER
			KIND OF PROPERTY		EXTENT AND TYPE OF DAMAGE							
	INDEPENDENT WITNESS		NAME		STREET ADDRESS			CITY		STATE	ZIP	PHONE NUMBER
NAME			STREET ADDRESS			CITY		STATE	ZIP	PHONE NUMBER		
SECTION 4 DETAILED DESCRIPTION OF ACCIDENT	ACCIDENT DATE	HR	WEATHER		LOCATION OF ACCIDENT - STREET OR HIGHWAY				CITY			
	ACCIDENT DIAGRAM	Show & Label: Roads, Traffic Units, the Travel Direction		North: Indicate		DESCRIBE ACCIDENT briefly: identify units by numbers. Also identify other OBJECTS DAMAGED & NATURE OF DAMAGE (Property other than vehicles)						
												
	DATE OF THIS REPORT		EMPLOYEE SIGNATURE									

VEHICLE ACCIDENT OR DAMAGE REPORT (PAGE 2)

STARS CLAIM NUMBER

EMPLOYEE WORK STATUS	DID THE EMPLOYEE SEEK MEDICAL TREATMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide Name, Address, Phone:		
	WAS WORKERS' COMPENSATION INCIDENT REPORT FORM COMPLETED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	HOURS OF CONTINUOUS DUTY FOR EMPLOYEE DRIVER?	WAS THE EMPLOYEE FOLLOWING COUNTY PROCEDURE(S)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	YEARS OF EXPERIENCE DOING THIS JOB		
CAUSES	FACTORS CONTRIBUTING TO THE INCIDENT <i>(Check all that apply)</i>		
	<input type="checkbox"/> INATTENTION <input type="checkbox"/> ATTITUDE <input type="checkbox"/> PHYSICAL IMPAIRMENT <input type="checkbox"/> UNSAFE EQUIPMENT <input type="checkbox"/> EQUIPMENT FAILURE <input type="checkbox"/> FATIGUE <input type="checkbox"/> LACK OF TRAINING <input type="checkbox"/> IMPROPER MAINTENANCE <input type="checkbox"/> DRIVING TOO FAST FOR CONDITIONS <input type="checkbox"/> INEXPERIENCE <input type="checkbox"/> LIGHTING (CHECK THE ONE THAT APPLIES) <input type="checkbox"/> OTHER, EXPLAIN <input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DUSK/DAWN <input type="checkbox"/> NIGHT <input type="checkbox"/> SHADOWS <input type="checkbox"/> SUN/GLARE		
HAS EMPLOYEE RECEIVED PREVIOUS NOTICES OR WARNINGS ABOUT THEIR UNSAFE ACTS OR CONDITIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when Oral or Written			
CORRECTIVE ACTION	WHAT ACTION HAS BEEN TAKEN TO CORRECT OR ELIMINATE THE UNSAFE ACT OR CONDITION <i>(Check all that apply)</i>		
	<input type="checkbox"/> DISCUSSED INCIDENT WITH EMPLOYEE <input type="checkbox"/> DISCUSSED INCIDENT WITH OTHERS THAT DO THE SAME WORK <input type="checkbox"/> EMPLOYEE RETRAINED <input type="checkbox"/> PROVIDED TRAINING/RETRAINING TO ALL EMPLOYEES <input type="checkbox"/> REPAIRED EQUIPMENT OR CONDITION <input type="checkbox"/> VERIFIED SAFETY EQUIPMENT IS OPERABLE, AVAILABLE <input type="checkbox"/> INITIATED DAILY SAFETY LOGS <input type="checkbox"/> INSTITUTED INSPECTION PROGRAM <input type="checkbox"/> REVIEWED POLICY & PROCEDURE WITH EMPLOYEE <input type="checkbox"/> OTHER, PLEASE EXPLAIN <input type="checkbox"/> REQUESTED MODIFICATION OF EQUIPMENT <input type="checkbox"/> RECOMMENDED CHANGES TO POLICY & PROCEDURE		
PREVENTABLE? <input type="checkbox"/> Yes, How? <input type="checkbox"/> No, Why,?			
SUPERVISOR COMMENTS	ADDITIONAL COMMENTS		
SIGNATURE	SIGNATURE OF SUPERVISOR & PRINTED NAME	DATE	DATE YOU WERE NOTIFIED OF INCIDENT
	TELEPHONE NUMBER	SECTION IDENTIFICATION	
	BUSINESS UNIT/COST CENTER NUMBER	MAIL STOP NUMBER	

FOR OFFICE USE		
PERSON ENTERING DATA INTO STARS	PHONE NUMBER	DATE