



# Employee Accident Reporting Form

Disclaimer: The statements in this accident form are provided in anticipation of litigation and are for the sole use of the County of Racine.

Incident Date:

## Section I – Employee Information

Driver's Name:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No
Driver's License No.		D.L. State:	
Employee ID No.:	Department:	Work Phone:	
Supervisor:		Supervisor Phone:	

## Section II - Shift and Trip Information

Employee Shift Start:	A.M. P.M.	Employee Shift End:	A.M. P.M.	Accident Occurred While Employee on Overtime:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Origin:		Destination:		Trip Began:	A.M. P.M.
Purpose of Trip:					
Was there any deviation from direct route?	<input type="checkbox"/> Yes - Explain: <input type="checkbox"/> No				

## Section III - County Vehicle Information

Vehicle Make:		Vehicle Model:		Vehicle Year:	
License Plate:		Department:			
Describe Vehicle Damage:					
Passenger Name:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No	Home phone:	
Home Address:		City:		State:	Zip:
Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Department:		Work Phone:		

Passenger Name:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No		Home phone:	
Home Address:		City:		State:		Zip:
Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Department:				Work Phone:	
<b>Section IV - Other Vehicle Information</b> (Use Section X if additional space is needed)						
Driver's Name:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No			
Driver's License No.:					D.L. State:	
Work Address:		City:		State:		Zip:
Home Address:		City:		State:		Zip:
Work phone:			Home/ Cell Phone:			
<b>Owner's Information (if different than driver)</b>						
Home Address:		City:		State:		Zip:
Work Phone:			Home/Cell Phone:			
Vehicle Make:		Vehicle Model:			Vehicle Year:	
License Plate and State:			Vehicle is:	<input type="checkbox"/> Owned <input type="checkbox"/> Privately Owned <input type="checkbox"/> Leased <input type="checkbox"/> Rented		
Describe Vehicle Damage:						
Driver's Insurance Company:				Policy Number:		
Insurance Address:				Insurance Phone Number:		
Passenger Name:		Home phone:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No	
Home Address:		City:		State:		Zip:
Passenger Name:		Home phone:		Injured?	<input type="checkbox"/> Yes (Complete Section V) <input type="checkbox"/> No	
Home Address:		City:		State:		Zip:

**Section V - Injuries**  
(Use Section X if additional space is needed)

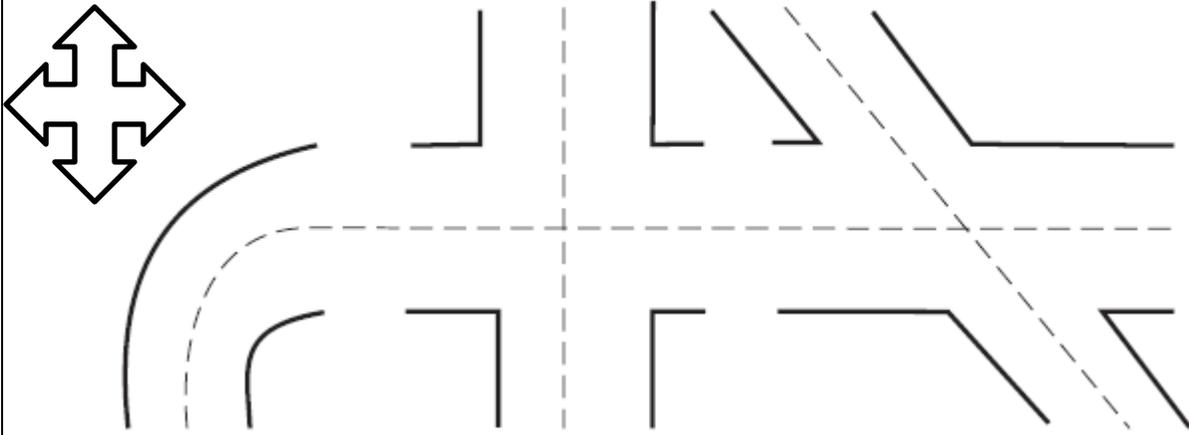
Name:				Sex:		DOB:			
Home Address:			City:			State:		Zip:	
Phone Number:			<input type="checkbox"/> Fatality <input type="checkbox"/> Injured	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian	<input type="checkbox"/> Passenger <input type="checkbox"/> Helper	Wearing Seatbelt:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In which vehicle:				Location in vehicle:					
Describe injuries and treatment:									
Transported by:				Transported to:					

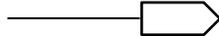
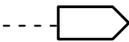
Name:				Sex:		DOB:			
Home Address:			City:			State:		Zip:	
Phone Number:			<input type="checkbox"/> Fatality <input type="checkbox"/> Injured	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian	<input type="checkbox"/> Passenger <input type="checkbox"/> Helper	Wearing Seatbelt:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In which vehicle:				Location in vehicle:					
Describe injuries and treatment:									
Transported by:				Transported to:					

**Section VI - Accident Information**

Date of Accident:			Time of Accident:	A.M. P.M.	Date reported:		
Name of Supervisor Notified:					Time supervisor notified:	A.M. P.M.	
Location of Accident and Nearest Cross Streets:							
Weather Conditions at Time of Accident:	<input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Sleet/Hail <input type="checkbox"/> Foggy <input type="checkbox"/> Cloudy <input type="checkbox"/> Other: _____	Road Conditions at time of Accident:	<input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Snow/Slush <input type="checkbox"/> Other: _____	Traffic at Time of Accident:	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Stopped <input type="checkbox"/> Other: _____		

Complete the following diagram to show direction and positions of automobiles or property involved, clearly designating point of contact. Select the street group that best represents the location of your accident or sketch in the available space. Give street names, directions, and locations of objects involved. Indicate location of any traffic control devices. Use the arrows to indicate NORTH.



- Use solid line to show path before accident  And broken line after the accident 
- Number each vehicle; County Vehicle should be 1, and continuing with each additional vehicle
- Show railroad by ++++++
- Show motorcycle or bicycle by o-o
- Show pedestrian by O

**Describe the accident.** Include information regarding the posted speed limit, approximate speed of the vehicles, condition of accident vehicles, traffic controls, lighting conditions, and driver actions and/or statements. Attach additional pages if needed.

**Section VII - Witnesses**  
(Use Section X if additional space is needed)

Name:		Sex:		DOB:			
Home Address:		City:		State:		Zip:	
Home Phone:		Work Phone:					

Name:				Sex:		DOB:			
Home Address:			City:			State:		Zip:	
Home Phone:				Work Phone:					
<b>Section VIII - Property Damage (Other than vehicles)</b>									
Name of Owner:					Telephone:				
Home Address:			City:			State:		Zip:	
Item Damaged:			Location of Damaged Item:			Estimated Cost:	\$		
Owner's Insurance Company:				Policy Number:					
Insurance Address:				Insurance Phone Number:					
<b>Section IX - Police Information</b>									
Officer Name:					Officer Unit No:				
Department:				Report No:					
Person cited/charged:				Violation(s):					
<b>Section X - Additional Information</b> <i>(Attach additional pages if necessary)</i>									
<b>Section XI - Required Attachments:</b>									
<input type="checkbox"/> Assignment sheet									
<input type="checkbox"/> Location Map									
<input type="checkbox"/> Photographs					How many:				
<input type="checkbox"/> Employee's Written Statement									
<input type="checkbox"/> Wisconsin Motor Vehicle Report or Responding Police Agency's Incident Report									
<b>Section XII - Signatures</b>									
Employee Signature:					Date:				
Supervisor Signature:					Date:				
<p>This form <u>MUST</u> be filled out the day of the incident/accident and submitted to the Supervisor or Highway Superintendent ASAP. If employee injury(s) does not allow for the form to be filled out the day of the incident/accident, the employee must complete the form immediately upon his or her return to work.</p>									