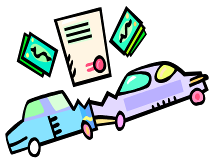

MANATEE COUNTY VEHICLE CRASH REPORT

*To be completed by the employee involved in a **vehicle collision** or to report vehicle **damage** or **vandalism**. Reports must be reviewed by a supervisor and signed off by both the supervisor and the Division Manager. Report all accidents immediately to the Risk **Management Division** at 745-3750. Forward completed **original report to Risk Management within 24 hours.** Also forward a copy of the report to the **Department Director** and **Fleet Services**. Use a supplemental sheet if necessary.*

PRINT ONLY

DATE: ________________ TIME: ________________ COST CENTER: ____________________________

RISK MANAGEMENT NOTIFIED & SPOKE WITH:____________________ DATE: ________ TIME: _________

INCIDENT LOCATION: ____

LAW ENFORCEMENT: MSO FHP OTHER_____ REPORT #:________________________________

CITATION?: ________________ ________________

Employee Other

WITNESSES

1. ____________________________ Name
   ____________________________ Street Address
   ____________________________ City, State & Zip Code
   ____________________________ Phone Number

2. ____________________________ Name
   ____________________________ Street Address
   ____________________________ City, State & Zip Code
   ____________________________ Phone Number

3. ____________________________ Name
   ____________________________ Street Address
   ____________________________ City, State & Zip Code
   ____________________________ Phone Number

EMPLOYEE

Name: ________________________________

Department: Public Works / Transit

Employee ID: ________________________________

Vehicle Asset #: ________________________________

Conditions at the time of the collision:
Weather? Road? Traffic? Other

____

Vehicle Towed? ________________________

NON-EMPLOYEE

Driver's Name: ________________________________

Address: ________________________________
Street City State Zip Code

Phone #: ________________________________

Vehicle Make: __________ Model __________ Year _____

Insurance Co:_______________ Policy #: __________

Owner's Name: ________________________________

Address: ________________________________
Street City State Zip Code

Phone #: ________________________________

Insurance Co:_______________ Policy #: __________

Vehicle Towed?________________________________

EMPLOYEE (Continued)

Transport to Hospital ____________________
or authorized medical facility?

NON-EMPLOYEE (Continued)

Transport to Hospital? ____________________

Nature of Injury: ____________________

Other Employees in Vehicle?

1. ____________________

2. ____________________

Medical Treatment? ____________________

Ambulance Transport? ____________________

Other Occupants / Injuries?

1. ____________________

2. ____________________

Medical Treatment? ____________________

Ambulance Transport? ____________________

DESCRIPTION OF ACCIDENT (if more space is needed use separate sheet):

DIAGRAM

Report Prepared By: ____________________ Signature: ____________________ Date: __________

Employee's Signature

SECTION BELOW TO BE COMPLETED BY SUPERVISOR

1. Based on Human Resources' post-accident testing criteria (matrix), was the employee drug tested? ________________
   If "NO", please list justification(s). Examples: At the time of the accident, the employee was completely discounted as a contributing factor, etc.

   ____

2. Was the accident avoidable by the employee/driver? ________________

3. Is there a reason to believe the employee is on other prescription medication/over-the-counter drugs? ________________

Supervisor – Print Name: ____________________ Date: ________________

____________________ ________________

Division Manager Date