

PINAL COUNTY RISK MANAGEMENT

EMPLOYEE'S REPORT OF A VEHICLE/EQUIPMENT ACCIDENT/INCIDENT

IF ADDITIONAL SPACE IS NEEDED PLEASE CONTINUE ON A SEPERATE SHEET OF PAPER

Accident Location (street address):		Date and Time of Accident:	
Intersecting Street or Highway and Mile Post Number:		<input type="checkbox"/> Intersection <input type="checkbox"/> Non-intersection	
City:	City Limits: <input type="checkbox"/> Inside <input type="checkbox"/> Outside	County:	
Weather/Road Conditions:	Number of Vehicles Involved:	Number of Persons Injured:	
Vehicle/Equipment involved with: (Check appropriate boxes)	<input type="checkbox"/> Pedestrian <input type="checkbox"/> Other vehicle <input type="checkbox"/> Other (Explain):	<input type="checkbox"/> Other County Vehicle No. <input type="checkbox"/> Fixed Object	

COUNTY VEHICLE INFORMATION

YEAR:	MAKE:	MODEL:	LICENSE PLATE NUMBER:	VEHICLE ID NUMBER (VIN):
REMOVED TO:			REMOVED BY:	
EMPLOYEE DRIVER'S NAME:			DEPARTMENT:	
EMPLOYEE WORK ADDRESS:			WORK PHONE NUMBER:	CELL PHONE NUMBER:
CITY/TOWN:	DRIVER'S LICENSE NO.:	CLASS:	EXPIRATION DATE:	STATE:
JOB TITLE:		POINT OF IMPACT OR DAMAGE ON COUNTY VEHICLE:		

OTHER VEHICLE INFORMATION

YEAR:	MAKE:	MODEL:	LICENSE PLATE NUMBER AND STATE:	VEHICLE ID NUMBER (VIN):
REMOVED TO:			REMOVED BY:	
DRIVER'S NAME:			WORK PHONE NUMBER:	HOME PHONE NUMBER:
DRIVER'S ADDRESS:		CITY/TOWN:	STATE:	ZIP:
DRIVER'S LICENSE NO.:	CLASS:	EXPIRATION DATE:	STATE AND ZIP:	DRIVER/OWNER SAME PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO
OWNER'S NAME:			WORK PHONE NUMBER:	CELL PHONE NUMBER:
OWNER'S ADDRESS:		CITY/TOWN:	STATE:	ZIP:
INSURANCE COMPANY:	POLICY NUMBER AND EXPIRATION DATE		AGENT:	PHONE NUMBER:
PROPERTY DAMAGE:			ESTIMATED COST TO REPAIR:	
NAME OF PROPERTY OWNER:		ADDRESS:	CITY/TOWN	STATE AND ZIP:

INJURIES INFORMATION

NAME:	ADDRESS:	CITY/TOWN:	STATE & ZIP:	HOME & CELL PHONE NUMBER(S):
INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOSPITAL NAME:	CITY /TOWN:	
DESCRIBE INJURIES:				
PERSON INJURED: <input type="checkbox"/> DRIVER - COUNTY VEHICLE <input type="checkbox"/> PASSENGER - COUNTY VEHICLE <input type="checkbox"/> DRIVER - OTHER VEHICLE <input type="checkbox"/> PASSENGER - OTHER VEHICLE				

NAME:	ADDRESS:	CITY/TOWN:	STATE & ZIP:	HOME & CELL PHONE NUMBER(S):
INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOSPITAL NAME:	CITY /TOWN:	PHONE NUMBER:
DESCRIBE INJURIES:				

PERSON INJURED: <input type="checkbox"/> DRIVER - COUNTY VEHICLE <input type="checkbox"/> PASSENGER - COUNTY VEHICLE <input type="checkbox"/> DRIVER - OTHER VEHICLE <input type="checkbox"/> PASSENGER - OTHER VEHICLE				
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
WITNESSES				
Name:	Address:	City:	State & Zip:	Home & Cell Phone Number(s):
Name:	Address:	City:	State & Zip:	Home & Cell Phone Number(s):
Name:	Address:	City:	State & Zip:	Home & Cell Phone Number(s):


POLICE/SHERIFF REPORT			
AGENCY:	OFFICER & ID NUMBER:	REPORT NUMBER:	AGENCY PHONE NUMBER:
WERE COUNTY DRIVER AND PASSENGERS SEAT BELTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE OTHER DRIVER AND PASSENGERS SEATBELTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WAS COUNTY DRIVER CHARGED WITH A VIOLATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		WAS COUNTY DRIVER CHARGED WITH A VIOLATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WAS COUNTY DRIVER 'S DRIVER'S LICENSE SUSPENDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WAS OTHER DRIVER 'S DRIVER'S LICENSE SUSPENDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

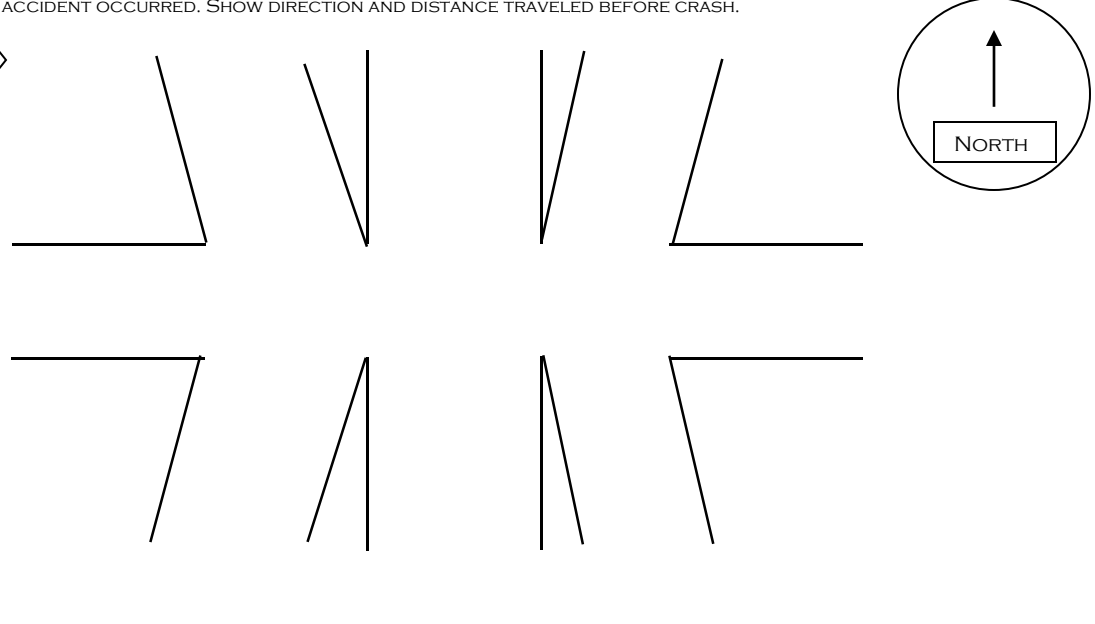
WHAT SPEED WAS COUNTY VEHICLE TRAVELING AT IMPACT?

DESCRIBE HOW THE ACCIDENT OCCURRED:

DRAW A DIAGRAM OF HOW THE ACCIDENT OCCURRED. SHOW DIRECTION AND DISTANCE TRAVELED BEFORE CRASH.

SHOW YOUR VEHICLE AS: 

SHOW OTHER VEHICLE AS: 



I HEREBY CERTIFY THAT THIS IS A TRUE STATEMENT OF FACTS TO THE BEST OF MY KNOWLEDGE AND BELIEF:

DRIVER'S SIGNATURE:	DATE:
SUPERVISOR'S SIGNATURE:	DATE:

COMPLETE FORM AND SEND TO RISK MANAGEMENT WITHIN 24 HOURS OF THE EVENT/ACCIDENT
RISK MANAGEMENT PHONE NUMBERS: 520-866-6236
FAX NUMBER: 520-866-6477
EMAIL: RISKMGMT@PINALCOUNTYAZ.GOV