ACCIDENT/INCIDENT REPORT FORM

- ✓ Immediate supervisor and/or employee should complete this form promptly and completely. Complete all areas that apply to this accident/incident.
- ✓ Print clearly.
- ✓ Forward a copy to the Clerk Auditor/Risk Manager and the Human Resources Department **as soon as practical, but no later than48 hours, or the end of the next workday**. If incident happens on a holiday or weekend, in an emergency situation please contact JoAnn Evans @ 435 733-1158 or Lisa Henrie @ 801 301-3318.
- ✓ **Attach additional sheets if necessary.**

Type Of Loss (Circle One): ***Automobile*** ***General Liability*** ***Property*** ***Injury***

Kind Of Loss (Circle All That Apply):

Elk/Deer ***Hail/Wind/Rain/Ice/Snow/Water/Mud*** ***Collision*** ***Slip/Fall*** ***Explosion***
Other:_____

Date of Occurrence: _____ Time of Occurrence: _____ Date & Time Reported: _____

Reported to Whom: _____County Dept. Involved: _____ Dept. Contact: _____

Witness (es):_____Time Work Day Began:_____ AM/PM

Location Of Accident/Incident: _____

Description Of Occurrence **(Include All Equipment, Materials, And Chemicals Used):** _____

_____

Did another person not employed by Duchesne County cause the accident/incident? ☐ Yes ☐ No

If yes, Name: _____ Address: _____ Phone: _____

What actions, events, or conditions contributed most to this incident/accident? _____

_____

_____

Could anything have been done to prevent this type of incident/accident? ☐Yes ☐No If Yes, What? _____

_____

_____

Were safeguards in place? ☐Yes ☐No If no, why?:_____
Was safety equipment provided? ☐ Yes ☐No Was the equipment used? ☐ Yes ☐No If no, why?:_____

_____

INJURY INFORMATION

Injured Name: _____ Address: _____ Phone: _____
Social Security Number: _____ Birthdate: _____
Describe Injuries (**Part Of Body & Type Of Injury**): _____

_____

Was Medical Treatment Given? Yes No Date & Time Given: _____
If Yes, Please Describe What Medical Care Was Provided: _____

_____

Name Of Doctor & Hospital:_____

Witness Name: _____ Address: _____ Phone: _____

Witness Name: _____ Address: _____ Phone: _____
Witness Name: _____ Address: _____ Phone: _____

Please attach Separate Sheets for Witness Statements.

COUNTY VEHICLE INFORMATION FOR ACCIDENTS

County Vehicle used with permission: ☐ Yes ☐No

Authorities Contacted: ☐ Yes ☐No Report #: _____ Name Of Investigating Officer: _____

Year_____ Make _____ Model_____ Plate # _____

Vin #_____

Driver's Name:_____ Driver's Phone #: _____Driver's License #: _____

Date of Birth: _____ Social Security Number: _____

Driver's Address: _____

Describe Damage: _____

_____

_____

Witness Name: _____ Address: _____ Phone: _____

Witness Name: _____ Address: _____ Phone: _____

Witness Name: _____ Address: _____ Phone: _____

Please attach Separate Sheets for Witness Statements.

OTHER VEHICLE INFORMATION

Owner's Name: _____ Address: _____Phone: _____

Driver's Name: _____ Address: _____ Phone: _____

Driver's License #: _____ Insured By: _____

Policy #: _____ Insurance Company Phone #: _____

Describe Property Damage _____

Year_____ Make _____ Model_____ Plate # _____

Vin #_____

Witness Name: _____ Address: _____ Phone: _____

Witness Name: _____ Address: _____ Phone: _____

Witness Name: _____ Address: _____ Phone: _____

Please attach Separate Sheets for Witness Statements.

Actions Or FollowUp:_____

_____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Clerk Auditor/Risk Mgt Initials:_____

Date Received:_____

HR Representative Initials:_____

Date Received:_____

PLEASE COMPLETE BOTH SIDES REV 03/15