

Of Occupants: _____ # Seated: _____ # Standing: _____ # Injured: _____

Was Vehicle Towed: Yes No By Whom: _____

43.) Type of Collision:

Other Vehicle Fixed Object Bicyclist Pedestrian Animal Train Off Road Equipment

44.) If a Non County Owned Vehicle was involved, please complete the following information:(If more than two vehicle, please use an additional sheet for their information)

Name of Driver _____ Phone # _____

Address _____

Date of Birth: _____ Sex: M F Drivers Lic. #: _____ Lic. State: _____

Of Occupants: _____ Year: _____ Color: _____ Make/Model: _____

VIN Number: _____ Tag Number: _____ Tag State: _____

Was Vehicle Towed: Yes No By Whom: _____

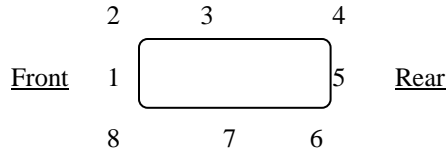
Insurance Company: _____

Owner of Vehicle (if Different from Driver): _____

Phone #: _____ Address: _____

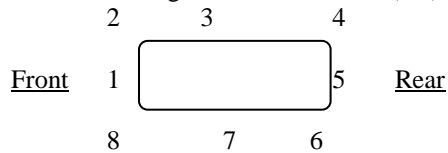
45.) Damage Information: (County Equipment is V1 and other equipment is V2)

Indicate damage on County Vehicle (V1):



- 0 = None
- 9 = Top
- 10 = Under carriage
- 11 = Totaled
- 12 = Other

Indicate damage on Other Vehicle (V2):



- 0 = None
- 9 = Top
- 10 = Under carriage
- 11 = Totaled
- 12 = Other

46.) Pre-Incident Movement: (Please X all that apply)

V1	V2/OV		V1	V2/OV	
		Going Straight Ahead			Exiting Vehicle
		Making Right Turn			Entering Vehicle
		Making Right on Red			Slowing or Stopping
		Making Left Turn			Stopped at Traffic
		Making U Turn			Parked
		Changing Lanes			Avoided Object in Road
		Passing			Vehicle Lights On
		Merging			Vehicle Lights Off
		Backing			Emergency Flashers / Strobes Lights Activated
		Other			Left Turn Signal On
		Vehicle was parked			Right Turn Signal Off

Posted Speed Limit _____

Estimated Speed _____

Direction of Travel _____

V1 = _____ MPH

V1 = _____ MPH

V1 = N S E W

V2 = _____ MPH

V2 = _____ MPH

V2 = N S E W

Pedestrian / Bicyclist Action

Place Employee First & Last Initial Here

<input type="checkbox"/>	Crossing with signal
<input type="checkbox"/>	Crossing no signal or crosswalk
<input type="checkbox"/>	Crossing against signal
<input type="checkbox"/>	Crossing no signal or marked crosswalk
<input type="checkbox"/>	Going to/from stopped bus
<input type="checkbox"/>	Other


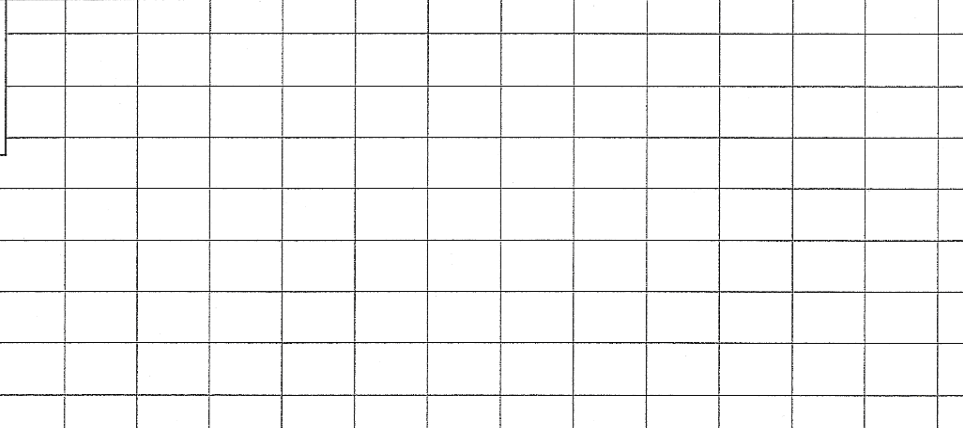

<input type="checkbox"/>	Riding/walking along highway with traffic
<input type="checkbox"/>	Riding/walking along highway against traffic
<input type="checkbox"/>	Emerging from in front/behind parked vehicle
<input type="checkbox"/>	Getting in/out of vehicle (Not Bus)
<input type="checkbox"/>	Pushing/working on vehicle
<input type="checkbox"/>	Working on roadway

Collision Type

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Backing | <input type="checkbox"/> Merging | <input type="checkbox"/> Sideswipe |
| <input type="checkbox"/> Head-On | <input type="checkbox"/> Right Angle | <input type="checkbox"/> Passing |
| <input type="checkbox"/> Rear-ends Vehicle | <input type="checkbox"/> Vehicle Rear-ends Bus | <input type="checkbox"/> Sudden Stop |
| <input type="checkbox"/> Right Mirror | <input type="checkbox"/> Left Mirror | <input type="checkbox"/> Ran off Road |
| <input type="checkbox"/> Wheelchair Lift Operations | <input type="checkbox"/> Door Operation | <input type="checkbox"/> Other _____ |

Police Investigated: Yes No Police Department: _____
 Officer Name (Badge #): _____ Report Number: _____
 Citation/ Arrest: None issued Operator 1 Operator 2 Bicyclist Pedestrian

47.) Collision Diagram

 Indicate North by Arrow		<p>Please draw a diagram of the roadway or streets where the crash occurred, indicating the vehicles involved and direction of travel using the following symbols:</p> <p>→ = Direction <input type="checkbox"/> 1 = Vehicle 1 (Your Vehicle) <input type="checkbox"/> 2 = Vehicle 2 ○ = Pedestrian/Non-motorist  = North</p> <p>Select one of the following if the crash did not occur on a public way:</p> <p><input type="checkbox"/> Off-street parking lot <input type="checkbox"/> Garage <input type="checkbox"/> Mall/shopping center <input type="checkbox"/> Other private way</p>
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(A) Use solid line to show path of each vehicle before collision
 (B) Use dotted line to show path of vehicle after collision.

48.) Please explain any **other** unsafe act(s) or hazardous condition(s) that could have contributed to this incident (give details):

49.) List any corrective action suggested, or any action to be taken: ****NOTE** It is the overall responsibility, of the Appointed Department Director to complete or deny Corrective Actions as suggested.**

50.) Person and Position Title to whom corrective action was assigned:

Place Employee First & Last Initial Here _____

51.) Date corrective action to be completed:
52.) Comments:

Direct Supervisor Signature / Date

Injured Employee Signature / Date

Safety Coordinator Signature/ Date

Risk Manager Signature / Date

Personnel Director Signature / Date

Appointed Dept. Director Signature / Date

County Commission Chairman Signature / Date

Place Employee First & Last Initial Here _____