VEHICLE, EQUIPMENT OR PROPERTY DAMAGE REPORT

The City of Gardner is to be advised of all accidents within 24 hours. This report, along with a police report, if necessary, is to be submitted to Risk Management within 24 hours of occurrence of all accidents involving scheduled vehicles, equipment or property.
This information is for use in preventing similar accidents in the future and, if necessary, filing insurance claims.

PLEASE PRINT CLEARLY AND LEGIBLY

STATEMENT OF LOSS

Employee's Name: _____ **Date of Report:** _____

Employee's Department/Division: _____

Supervisor's Name: _____

Year and Make of Vehicle: _____ **License Tag No.:** _____

Vehicle Fleet No.: _____

1. **Date of Accident:** _____ Day of Week _____ Time of Day_____ AM/PM
2. **Location of Accident:** _____
3. **Type of Accident or Damage:** _____ Vehicle _____ Equipment _____ Property

   Please describe the damage in detail: _____

   _____

   _____

4. **Conditions:** Weather _____ Road _____ Visibility _____
5. **Please describe the accident in detail:** _____

   _____

   _____

   _____

   _____

   _____

6. _____ **Photo(s) attached** _____ **Police Report attached**

   _____ **Diagram attached** _____ **Repair Estimates attached**

7. **Name of owner or department of other vehicle/property that was damaged:**

_____

Address: _____

Daytime Telephone No.: _____ Evening Telephone No.: _____

Year & Make of Other Vehicle: _____

License Tag No.: _____ Vehicle Fleet No.: _____

8. **Give location and description of property damage:**

_____

_____

9. **Injuries: Yes** _____ **No** _____

If yes, to whom and what type? _____

_____

_____

_____

10. **Witness Statement:**

_____

_____

_____

_____

Witness Signature: _____ Date: _____

Witness Print Name: _____

(If additional space is needed please attach a separate Witness Report found in Shared Documents on CNET)

11. **Which authorities notified?** Gardner PD _____ County Sheriff _____ Highway Patrol _____

Additional Comments: _____

_____

_____

_____

_____ _____

Employee's Signature Date

_____

Printed Name

SUPERVISOR'S STATEMENT

1. **Did the driver or employee notify a supervisory person immediately after the accident?**

   _____ Yes If Yes, please list date and time of notification: _____

   _____ No If not, why? _____

   _____

2. **Did the driver, operator, or employee notify a Law Enforcement agency immediately?**

   _____ Yes If Yes, please list date and time of notification: _____

   _____ No If not, why? _____

   _____

3. **Was a ticket issued by a Law Enforcement agency?** _____ Yes _____ No

   If Yes, what type of offense?: _____

4. **List any additional data the employee did not outline:**

   _____

   _____

5. **In your opinion, could this driver/operator/employee have avoided this accident?**

   _____ Yes _____ No Please explain: _____

   _____

   _____

6. **What corrective measures would you recommend for the driver/operator/employee in order to prevent a future occurrence of the same nature?**

   _____

   _____

   _____

   _____

   _____

   _____

I HAVE INVESTIGATED THIS INCIDENT AND HAVE FOUND THE ABOVE TO BE TRUE.

_____ _____
Supervisor's Signature Date

_____
Printed Name

DEPARTMENT DIRECTOR'S STATEMENT

1. **Specifically indicate what actions/measures are needed to improve the areas of thinking, communications, policies/procedures or inspections to prevent this type of accident from happening again?**

_____

_____

_____

_____

2. **What immediate action has been taken to prevent the recurrence of a similar accident?**

_____

_____

_____

_____

THE FOLLOWING ACTIONS WILL BE IMPLEMENTED OR CORRECTED AS SOON AS POSSIBLE.

_____

_____

_____

_____

_____

_____ _____
Department Director Signature Date

_____
Printed Name

TO BE COMPLETED BY DEPT/DIVISION SAFETY COMMITTEE REPRESENTATIVE:

Comments: _____

_____

_____

_____ _____ _____

Safety Committee Rep Signature Printed Name Date

TO BE COMPLETED BY CITY ADMINISTRATOR

Comments: _____

_____

_____ _____

City Administrator Signature Date

_____

Printed Name

TO BE COMPLETED BY HUMAN RESOURCES MANAGER

Comments: _____

_____

_____ _____

Human Resources Manager Signature Date

_____

Printed Name

TO BE COMPLETED BY RISK COORDINATOR

Comments: _____

_____

_____

Date Worker's Comp Claim Filed: _____

Date Insurance Claim Filed: _____

_____ _____

Risk Coordinator Signature Date

_____

Printed Name