INCIDENT/ACCIDENT REPORT

Northwestern Ohio Community Action Commission

This form **MUST BE COMPLETED WTHIN 24 HOURS OF AN INCIDENT/ACCIDENT and YOUR SUPERVISOR/DIRECTOR MUST BE CONTACTED when no injury needing medical treatment beyond first aid has occurred.**

- **Employee must** submit the completed form to your supervisor/director.
- **Directors must** forward the form to the executive director.

This form **MUST BE COMPLETED and YOUR SUPERVISOR/DIRECTOR MUST BE CONTACTED IMMEDIATELY when injury needing medical treatment has occurred.**

- **Employee must submit** the completed form to your supervisor.
- **Supervisor must** initiate an immediate investigation and complete the **NOCAC Accident Analysis Report** form.
- **Supervisor must** forward both forms to the director.
- **Directors must** forward both forms to the executive director.

Name of Employee or client(s) involved: _____

Supervisor: _____ Name of Employee completing this report: _____

INCIDENT/ACCIDENT INFORMATION:

Date of Accident: _____ Time: _____ am _____ pm

Specific Location of incident or accident: _____

Detailed description of incident: _____

_____

Did you miss work due to incident or accident? _____ yes _____ no If yes, last date you worked? _____

Returned? _____ Was first aide provided? ____ yes ____no Was medical treatment required ____ yes ____ no

First Aid or Medical provider Name, Address & Phone: _____

_____

If applicable, name of consumers/others involved _____

Consumer/other's address: _____ Phone _____

If applicable, name of witnesses (Provide names, addresses & phone numbers):

_____

_____

VEHICLE ACCIDENT INFORMATION:

VEHICLE DESCRIPTION/# _____ DRIVEN FOR CLASSROOM _____ HOME BASE _____ OTHER _____

Which of the following state driver training programs have you completed?

PRE-SERVICE ___ BASIC ED. ___ ADVANCED ___ SPECIAL ED. ___

Have you attended a local in-service workshop this year? Yes ___ No ___

ACCIDENT INFORMATION: (To be completed by driver)

Use of vehicle at time of the accident was: routine trip ___ non-routine trip ___ personnel ___

If other than routine scheduled trip, please explain: _____

Number of: injuries inside ___ injuries outside ___ fatalities inside ___ fatalities outside ___

NOTE: Use zero (0) to indicate none.

ACCIDENT DETAILS: (To be completed by driver and reviewed by supervisor)

At time of accident bus was:

Moving and: hit stationary object ___ hit moving object ___ ran off road ___ over turned ___
was hit by another vehicle ___ hit a pedestrian ___ skidded ___

Stopped and: loading students on school grounds ____ unloading students on school grounds _____
unloading students off school grounds ____ not loading or unloading students _____

This accident involved a: school bus ____ van ____ box truck ____ **and a:** car ____ farm vehicle ____ truck ____
RV ____ another school bus ____ bicycle ____ motorcycle ____ train ____ other type of bus ____ pedestrian ___
animal ____ guardrail ____ ditch ____ bridge ____ fence ____ pole ____ sign ____ culvert ____ building ____

none of the above (explain) _____

NOCAC driver's intended action at time of accident was to: turn right ___ turn left ___ stop ___ back ___ remain parked ___ go straight ___ pass ___ park ___ start forward ___ slow down __

Light conditions: _____ Weather conditions: _____

Road Conditions : _____ Rate of Speed: _____

OTHER VEHICLE DETAILS: (To be completed by driver)

Name of owner: _____ Address: _____

Make & year of car _____ Type _____ License No. _____ State _____

What side of street _____ What direction _____ Rate of speed _____mph

Name of Operator _____ (if other than owner) Address:_____

Operator's (driver) license no. _____ state issuing _____

Nature and extent of damage to other vehicle: _____

_____

Is owner/operator insured? Yes ___ No ___ Insurance company? _____

WITNESSES:

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

REPORTING ACCIDENT:

Name of law enforcement agency called _____ Location _____

Title of law enforcement official present _____

WAS TRAFFIC VIOLATION CITATION ISSUED TO ANYONE?

Driver of agency vehicle ____ Driver or other vehicle ____ Pedestrian ____ No citation issued ____ Unknown _____

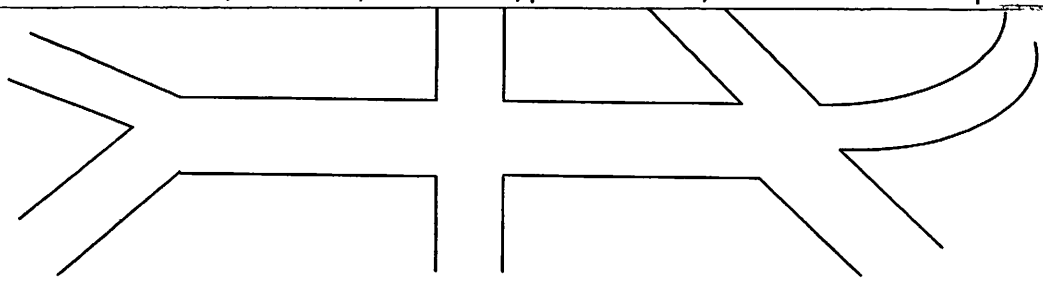
If issued – what was the charge, if known _____

DRIVER'S DESCRIPTION OF ACCIDENT (explain in detail) _____

_____

_____

SHOW: Parked cars, skid marks, obstructions, position of cars, direction of travel and point of contact.



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OFFICE USE ONLY: Date of report _____ Report prepared by _____

Name of reviewing supervisor _____ Date reviewed _____

Do you feel driver was using defensive driving practices? Yes ___ No ___

Comments by supervisor _____

_____

_____

Transportation Specialist (if Head Start vehicle/driver involved) Signature _____

Date of Review _____ Other information/Comments _____

_____

Was post-accident drug/alcohol screening necessary? Yes ____ No ____ If yes, time of test _____ am/pm

Provider and location _____

Director _____ Date of Review _____

Executive Director _____ Date of Review _____

Finance Director (in case of insurance claims) _____ Date of Review _____

Claim number assigned _____ Estimated amount of claim _____

Estimates were obtained for repairs of damage from (vendors including name/address/phone _____

_____