

# AUTO ACCIDENT REPORT – BONNER COUNTY

***This form must be completed for all Auto Accidents with the Initial Incident Report.***



*Driver, please submit the completed forms to your supervisor along with any photos of the accident.*

*Supervisor, please submit the forms to Risk Management. ***This form is required for ALL Auto Accidents.****

## Personal Information

Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Department: \_\_\_\_\_

Is the driver an employee of Bonner County?      Yes      No      Was s/he on the job at the time of the accident?      Yes      No

## Claim Information Internal Claim ID#:

Date of Occurrence: \_\_\_\_\_ Time of Occurrence: \_\_\_\_\_ A.M.      P.M.

Location: \_\_\_\_\_

## Vehicle/Equipment Involved

Year/Make/Model: \_\_\_\_\_ Vehicle owned by Bonner County?      Yes      No

License No.: \_\_\_\_\_ Last four of VIN: \_\_\_\_\_ Mileage at time of accident: \_\_\_\_\_

Where is the vehicle currently located? \_\_\_\_\_

Describe how accident occurred: \_\_\_\_\_

Describe damage: \_\_\_\_\_

## Personal Injury

Were you injured?      Yes      No

***(If yes, please complete a Workers Compensation – Initial Incident Report and submit it to Risk.)***

## Third Party

Is there any third party injury and/or property damage that needs to be addressed?      Yes      No

If yes, name and contact information of third party and explanation of the injury and/or property damage: \_\_\_\_\_

## Investigation

Investigated?      Yes      No      If yes, agency? \_\_\_\_\_ Case Number \_\_\_\_\_ Charges \_\_\_\_\_

Witness Information (Name, address, phone): \_\_\_\_\_

**DRIVER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# "On the spot" vehicle accident report

## ACCIDENT INFORMATION

Date \_\_\_\_\_ Time \_\_\_\_\_  A.M.  Daylight  
 P.M.  Dark

### LOCATION:

Name of Street or Highway Number \_\_\_\_\_ (Closest Intersection or Landmark)

City, Town, County \_\_\_\_\_ (State)

### WEATHER:

- |                                  |   |                                      |  |
|----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> 1 Clear | <input type="checkbox"/> 2 Raining        | <input type="checkbox"/> 3 Snowing   | <input type="checkbox"/> 4 Fog         |
| <input type="checkbox"/> 5 Sleet | <input type="checkbox"/> 6 Dust/Smoke/Fog | <input type="checkbox"/> 7 High Wind | <input type="checkbox"/> 8 Other _____ |

### AREA:

- |  |                                       |                                  |  |
|--|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> 1 Residential | <input type="checkbox"/> 2 Commercial | <input type="checkbox"/> 3 Rural | <input type="checkbox"/> 4 Other _____ |
|--|---------------------------------------|----------------------------------|--|

### PAVEMENT

- |                                    |                                     |  |  |
|------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> 1 Asphalt | <input type="checkbox"/> 2 Concrete | <input type="checkbox"/> 3 Gravel/Dirt | <input type="checkbox"/> 4 Brick/Stone |
| <input type="checkbox"/> 5 Steel   | <input type="checkbox"/> 6 Wood     | <input type="checkbox"/> 7 Other _____ |  |

### CONDITION

- |  |                                |                                     |                                      |
|--|--------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> 1 Dry         | <input type="checkbox"/> 2 Wet | <input type="checkbox"/> 3 Slippery | <input type="checkbox"/> 4 Pot Holes |
| <input type="checkbox"/> 5 Other _____ |                                |                                     |                                      |

### DIRECTION:

	N	E	S	W	Other
Yours	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	_____
Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	_____

### SPEED:

	Posted	Actual when danger noticed
Yours	_____	_____
Other	_____	_____

### TRAFFIC CONTROL:

- Stop sign:
- |   |   |
|---|---|
| <input type="checkbox"/> 1 1 Way                | <input type="checkbox"/> 2 2 Way              |
| <input type="checkbox"/> 3 3 Way                | <input type="checkbox"/> 4 4 Way              |
| <input type="checkbox"/> 5 Yield                | <input type="checkbox"/> 6 Semaphore          |
| <input type="checkbox"/> 7 Police/Flag Person   | <input type="checkbox"/> 8 Railroad           |
| <input type="checkbox"/> 9 Uncont. Intersection | <input type="checkbox"/> Not an Intersection. |

### SEAT BELT:

Used  Not Used

### AIR BAG INFLATED:

Yes  No

## ACCIDENT DESCRIPTION

Briefly tell how the accident happened. Indicate movement of involved vehicles when hazard was first noticed, warning or evasive action taken and length and position of any skid marks.

---



---



---



---



---








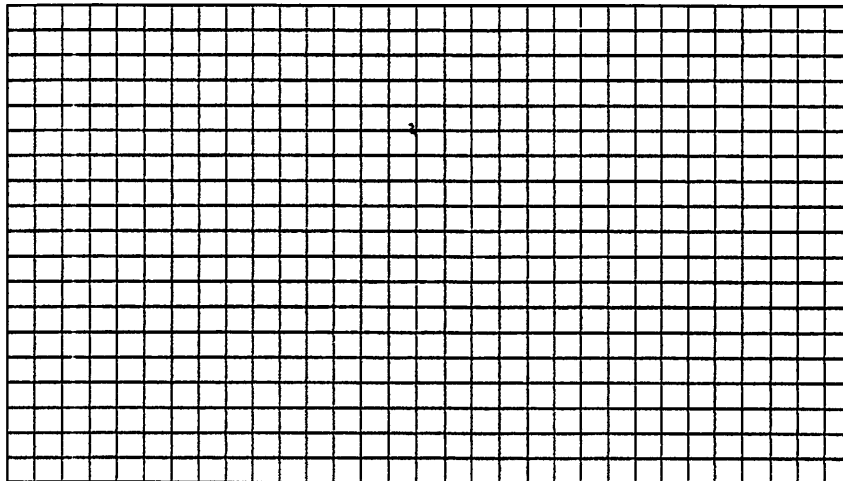
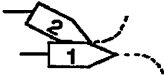
---


## ACCIDENT SKETCH

Draw an accident sketch. Show and label roadway, indicate number of lanes, direction of travel and signs. Number each vehicle and show direction of travel from point hazard was noticed to point of impact by a solid line and any travel after impact by a dotted line.

### SYMBOLS:

- Your Vehicle 1
- Other Vehicle: 2
- 3
- Pedestrian 
- Stop Sign 
- Semaphore 
- Yield 
- Railroad 
- Point of Impact



Indicate direction 

---

At what distance did you notice danger?

\_\_\_\_\_ feet