VEHICLE ACCIDENT OR DAMAGE REPORT

IMPORTANT INSTRUCTIONS This form must be completed for all damage or injury involving county vehicles within 24 hours. Enter the information into STARSWeb. Place the STARS claim number on the top right hand corner of page two. FAX the entire report to Risk Management at (410) 222-7640. Forward the original form to Risk Management at MS 9303.

PLEASE PRINT OR TYPE

Anne Arundel County, MD

SECTION 1 COUNTY VEHICLE #1

EMPLOYEE'S FIRST NAME MIDDLE LAST NAME	JOB TITLE		DATE OF BIRTH	HOME PHONE	
EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP	WORK PHONE	EXT
DEPT/SUB-DEPT/SECTION IDENTIFICATION	DEPT CODE		COUNTY VEHICLE NUMBER	TAG NUMBER	
DRIVER LICENSE NUMBER	CLASS	EXPIRES	STATE	SOCIAL SECURITY NUMBER	
IS VEHICLE DRIVABLE? ☐ Yes ☐ No	DRIVEN FROM SCENE? ☐ Yes ☐ No	INVESTIGATED BY: ☐ County ☐ State or ☐ City Police		REPORT NUMBER	
VEHICLE MAKE	VEHICLE MODEL		YEAR	WERE SEATBELTS BEING WORN? ☐ Yes ☐ No	
DESCRIPTION OF VEHICLE DAMAGE (Extent and Location)	WAS DRIVER INJURED? ☐ Yes ☐ No If Yes, describe:				
ON DUTY? ☐ Yes ☐ No	RESPONDING TO EMERGENCY? ☐ Yes ☐ No	WERE LIGHTS & SIREN ACTIVATED? ☐ Yes ☐ No			

PASSENGERS IN COUNTY VEHICLE	NAME(S) OF PASSENGERS	PHONE	ADDRESS	INJURIES	AGE

SECTION 2 OTHER VEHICLE #2

VEHICLE MAKE	YEAR	TAG NUMBER	IS VEHICLE DRIVABLE? ☐ Yes ☐ No	DRIVEN FROM SCENE? ☐ Yes ☐ No

NAME OF DRIVER	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
NAME OF OWNER	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

DESCRIPTION OF VEHICLE DAMAGE (Extent and Location)	WAS DRIVER INJURED? ☐ Yes ☐ No If Yes, describe:

PASSENGERS IN OTHER VEHICLE	NAME(S) OF PASSENGERS	PHONE	ADDRESS	INJURIES	AGE

INSURANCE COMPANY NAME	AGENT'S NAME	AGENT'S PHONE NUMBER	INSURANCE POLICY NUMBER

SECTION 3

3 OR MORE VEHICLES — Complete Section 2 on additional Vehicle Accident or Damage Report Forms

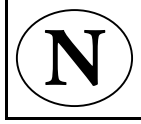
DAMAGE TO PROPERTY OTHER THAN AUTO	NAME OF OWNER	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
	KIND OF PROPERTY	EXTENT AND TYPE OF DAMAGE				
INDEPENDENT WITNESS	NAME	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
	NAME	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

SECTION 4 DETAILED DESCRIPTION OF ACCIDENT

ACCIDENT DATE	HOUR	WEATHER	LOCATION OF ACCIDENT - STREET OR HIGHWAY	CITY

ACCIDENT DIAGRAM — Show & Label: Roads, Traffic Units, the Travel Direction

North: Indicate



DESCRIBE ACCIDENT briefly: identify units by numbers. Also identify other OBJECTS DAMAGED & NATURE OF DAMAGE (Property other than vehicles)

DATE OF THIS REPORT	EMPLOYEE SIGNATURE

VEHICLE ACCIDENT OR DAMAGE REPORT (PAGE 2)

STARS CLAIM NUMBER

MUST BE COMPLETED BY SUPERVISOR

EMPLOYEE WORK STATUS

DID THE EMPLOYEE SEEK MEDICAL TREATMENT? ☐ Yes ☐ No
If Yes, provide Name, Address, Phone:

WAS WORKERS' COMPENSATION INCIDENT REPORT FORM COMPLETED? ☐ Yes ☐ No

HOURS OF CONTINUOUS DUTY FOR EMPLOYEE DRIVER?	WAS THE EMPLOYEE FOLLOWING COUNTY PROCEDURE(S)? ☐ Yes ☐ No
YEARS OF EXPERIENCE DOING THIS JOB	

CAUSES

FACTORS CONTRIBUTING TO THE INCIDENT *(Check all that apply)*

☐ INATTENTION ☐ ATTITUDE ☐ PHYSICAL IMPAIRMENT ☐ UNSAFE EQUIPMENT

☐ EQUIPMENT FAILURE ☐ FATIGUE ☐ LACK OF TRAINING ☐ IMPROPER MAINTENANCE

☐ DRIVING TOO FAST FOR CONDITIONS ☐ INEXPERIENCE ☐ LIGHTING (CHECK THE ONE THAT APPLIES)

☐ OTHER, EXPLAIN ☐ DAYLIGHT ☐ DUSK/DAWN ☐ NIGHT ☐ SHADOWS ☐ SUN/GLARE

HAS EMPLOYEE RECEIVED PREVIOUS NOTICES OR WARNINGS ABOUT THEIR UNSAFE ACTS OR CONDITIONS? ☐ Yes ☐ No
If Yes, when Oral or Written

CORRECTIVE ACTION

WHAT ACTION HAS BEEN TAKEN TO CORRECT OR ELIMINATE THE UNSAFE ACT OR CONDITION *(Check all that apply)*

☐ DISCUSSED INCIDENT WITH EMPLOYEE ☐ DISCUSSED INCIDENT WITH OTHERS THAT DO THE SAME WORK

☐ EMPLOYEE RETRAINED ☐ PROVIDED TRAINING/RETRAINING TO ALL EMPLOYEES

☐ REPAIRED EQUIPMENT OR CONDITION ☐ VERIFIED SAFETY EQUIPMENT IS OPERABLE, AVAILABLE

☐ INITIATED DAILY SAFETY LOGS ☐ INSTITUTED INSPECTION PROGRAM

☐ REVIEWED POLICY & PROCEDURE WITH EMPLOYEE ☐ OTHER, PLEASE EXPLAIN

☐ REQUESTED MODIFICATION OF EQUIPMENT

☐ RECOMMENDED CHANGES TO POLICY & PROCEDURE

SUPERVISOR COMMENTS

PREVENTABLE? ☐ Yes, How? ☐ No, Why,?

ADDITIONAL COMMENTS

SIGNATURE

SIGNATURE OF SUPERVISOR & PRINTED NAME	*DATE*	*DATE YOU WERE NOTIFIED OF INCIDENT*
TELEPHONE NUMBER	SECTION IDENTIFICATION	
BUSINESS UNIT/COST CENTER NUMBER	MAIL STOP NUMBER	

FOR OFFICE USE

PERSON ENTERING DATA INTO STARS	*PHONE NUMBER*	*DATE*