

CITY OF WISCONSIN RAPIDS
ACCIDENT / PROPERTY DAMAGE REPORT
(To be completed and reviewed by employee and immediate supervisor.)

SECTION I

Date of Accident: _____ Time: _____

Location of Accident: _____

Employee Name: _____ Job Title: _____

Date of Employment: _____ Length of Time in Job: _____

Was Employee Injured? Yes No

Private Property Damage (describe)

Estimated Amount of Damage \$ _____

Type of City Vehicle, Machinery, Equipment, Building, Property involved:

Type: _____ Unit No. _____ Estimated Damage \$ _____

Type: _____ Unit No. _____ Estimated Damage \$ _____

Witnesses to Accident:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Was a motor vehicle accident report filed? Yes No

* Was a post-accident drug and alcohol test administered? Yes No

* Post-accident drug and alcohol testing is required for a moving traffic accident, which:

1. Involves the loss of human life;
2. Results in the employee receiving a citation;
3. Involves personal injuries that require medical treatment away from the scene or if a vehicle is towed away, unless the employee can be completely discounted as a contributing factor.

SECTION II

A. In your own words, describe what happened. (To be completed by employee.)

B. Witness description of what happened.

C. Check all that apply.

	<u>Employee Complete</u>		<u>Supervisor Complete</u>	
1. Unsafe environmental factors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Unsafe mechanical factors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Unsafe physical conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Unsafe personal factors				
Lack of knowledge	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lack of training	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lack of skill	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Poor judgment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Unsafe act by another party	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above, please explain:

D. Were Proper Procedures Followed:

	<u>Employee</u>		<u>Supervisor</u>	
1. Correct tools/machine, etc., used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Safety devices used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Employee personal protection used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Supervisor's instructions used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

E. What action could have been taken to avoid accident, and what should be done to prevent a future accident?

1. Employee:

2. Supervisor:

SIGNATURES:

Employee: _____ Date: _____

Supervisor: _____ Date: _____

cc: Department Head