

**ALLIGATOR POINT / SAINT TERESA VOLUNTEER FIRE DEPARTMENT
ACCIDENT REPORT**

Type of accident being reported: *(check all that apply)*

☐ **Vehicle Accident** (vehicle-to-vehicle; vehicle-to-property; vehicle damage, other)

☐ **Personal Injury** (Workers= Compensation; minor injuries; citizen injury)

☐ **Private Property Damage/General Liability** (tire damage; paint damage; property damage)

Following an accident, this accident report is to be completed, signed and forwarded to the appropriate supervisor(s) for comment. Submit the report to Safety Officer within 24 hours.

Date of Accident:_____ **Time of Accident:**_____

SECTION 1: EMPLOYEE INFORMATION AND REMARKS

1. Member Information *(Use page 2 for additional injury information)*

Name _____ Length of Employment: _____ yrs. _____ months

License type: CDL___ Operator___

2. APSTVFD Vehicle Information *(if involved in a accident and/or if APSTVFD equipment is damaged)* Tag # _____

Vehicle # _____ Vehicle Make _____ Model _____ Yr.. _____ Use of vehicle at time of accident: _____ Describe

vehicle damages: ☐ front ☐ rear ☐ passenger-side ☐ driver-side ☐ windshield ☐ trailer

☐ mirror(s) ☐ undercarriage ☐ roof ☐ hood ☐ trunk ☐ tailgate ☐ tarp ☐ tire(s) ☐ other

Explain: _____

3. Private/Public Property Information *(may attach Exchange of Information provided by law enforcement)*

Owner of Damaged Property _____

Type and Extent of Damage _____

If applicable, Make of Vehicle _____ Model _____ Yr. _____ Tag # _____

Driver=s Name _____ Drivers License # _____

Address _____ Phone # _____

4. Investigation Information

Did local law enforcement investigate? _____ Officer=s Name _____ Case Number _____

Highway Patrol _____ Sheriff _____ City Police _____

Were pictures taken? _____ If so, by whom? _____

5. Injury Information *(to the best of your knowledge)*

Name _____ Address _____ Nature/Extent of Injury _____ Employee? or Citizen? _____

Injured person sent to doctor? Yes ☐ No ☐ Doctor or hospital name: _____

6. Witness Information

Name Address Phone # Employee? or Citizen?

7. Member statement of how accident occurred (attach sketch, if needed). Provide as much detail as possible (the accident; equipment failure, or other extenuating circumstances).

Title County Employee=s Signature Date

SECTION II: FIELD SUPERVISOR REMARKS**1. Describe apparent cause of accident/incident:****Contributing causes:****Unsafe behavior**

- ☐ violation of policy _____
☐ improper technique _____
☐ careless action _____
☐ other _____
☐ other _____

Unsafe conditions

- ☐ weather condition _____
☐ road surface _____
☐ un-level surface _____
☐ faulty equipment _____
☐ other _____

2. Was APSTVFD member documented at fault by law enforcement for the accident? Yes [] No []

Did employee require post-accident drug/alcohol testing as outlined in County policy? **Yes [] No []**

If "yes", employee sent for testing within four (4) hours? **Yes [] No []** If Ano@, explain:

Was there reasonable suspicion the driver or injured employee was under the influence of drugs and/or alcohol at the time of this accident? Yes [] No []

If Ayes@, drug and/or alcohol testing is to be initiated by documenting observable behavior on the Drug/Alcohol Test Reasonable Suspicion Form and the employee is to be escorted to the appropriate facility for testing.

Was there a death as a result of this accident? Yes [] No []

If Ayes@, drug and alcohol testing is required, regardless of who was at fault.

3. What steps were taken after the accident/incident to ensure the safety of others? _____ _____ _____	
_____ Supervisor Signature	_____ Date

SECTION III: PROGRAM SUPERVISOR or DEPARTMENT HEAD REMARKS

<u>1. Corrective Action(s) and/or Recommendation).</u> _____ _____	
_____ Safety Officer Signature	_____ Date

SECTION IV: SAFETY COMMITTEE REMARKS

<u>Safety Committee Comments/Recommendation:</u> <input type="checkbox"/> Safety Committee agrees with program supervisor=s corrective action(s) and/or recommendations. <input type="checkbox"/> Safety Committee does <u>not</u> agree with program supervisor=s corrective action(s) and/or recommendations. Comments: _____ _____ _____	
_____ Safety Committee Representative	_____ Date
<u>Division/Department Final Action</u> (if applicable) Procedure/Policy Change: _____ Disciplinary Action: _____ Concur with Accident Review Board (when applicable) Yes [] No[] <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> _____ Division/Department Signature </div> <div style="width: 45%; text-align: center;"> _____ Date </div> </div>	