



City of Fort Dodge Vehicle Accident/Incident Report

Must be completed as soon as reasonably possible by the individual involved and reviewed with their direct supervisor. Completed forms should be emailed to the department head and Human Resources immediately after completion.

Your Name: _____

Job Title: _____ Supervisor: _____

General Information

Date of Event: _____ Time of Event: _____ AM PM

What part of operator's workday? Entering or leaving work During normal work activities
 During meal period During break
 Working overtime Other _____

Location of the accident/incident: _____
Be as specific as possible, including building, street address, intersection, etc.

Type of accident: Backing Up Animal Head On
 Turned Over Sideswipe Rear End
 Fixed Object Right Angle Other (Describe) _____
 You Hit OR You Were Hit

Vehicle Information

Vehicle Year: _____ Make: _____ Model: _____

Vehicle Type: _____

Witness Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Injury Information

Was anyone injured? Yes No

Was anyone transported to the hospital? Yes No

Name of Individual(s) Injured: _____

Comments (type of injury, location of injury, etc.): _____

For a City employee injury, was the Company Nurse line called? Yes No

(888) 770-0928 * Search code: IMWCA

If during normal business hours, was the individual sent to UnityPoint Occupational Medicine for a drug/alcohol test?

Yes No

If after normal business hours, was a breath alcohol test performed by the local Police Department?

Yes No

Conditions

Weather: Clear Raining Snowing Sunny Cloudy Foggy Other: _____

Roadway: Dry Wet Slippery Under Repair Other: _____

Was the operator using texting or using cell phone without hands-free setup? Yes No

Did the vehicle have any defects? Yes No Describe: _____

Were seat belts in use? Yes No Comment: _____

Additional Comments: _____

Accident Information

Describe in detail the accident/incident: _____

Follow Up

What could have been done to prevent this accident/incident? _____

Additional Comments: _____

Signed by: _____ Date: _____
Employee Signature

Signed by: _____ Date: _____
Supervisor

Information provided on this report may form the basis for disciplinary action. All employees are expected to complete this form in detail, taking the time to ensure information is complete and correct. Please direct any questions to your director supervisor, your department head or Human Resources.