



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 InformationWas anyone injured? ☐ Yes ☐ NoWas 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 ☐ NoDid 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: _____

Accident Information Continued...

Describe the damage to the City vehicle: _____

_____ Was the vehicle towed? ☐ Yes ☐ No

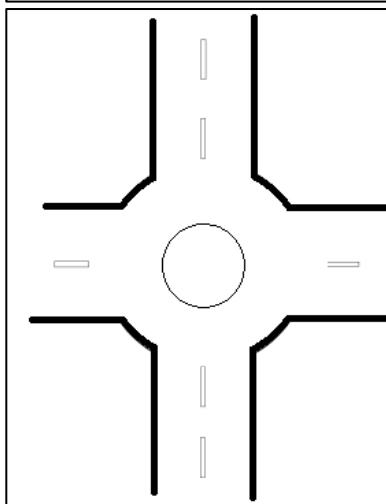
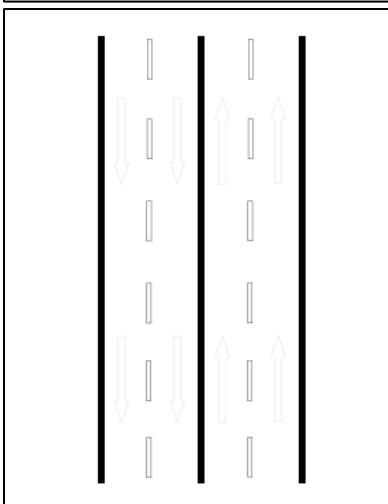
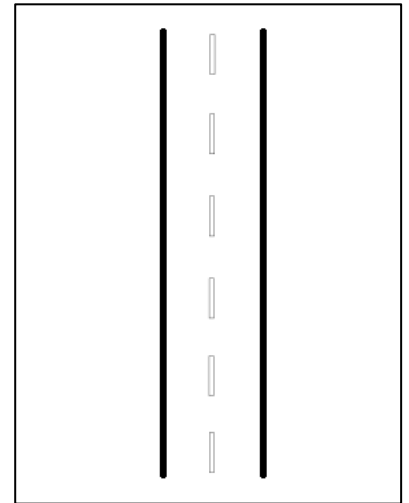
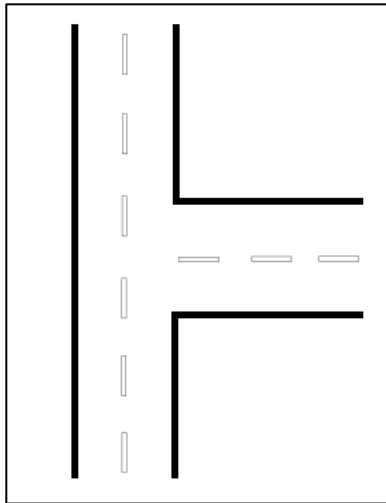
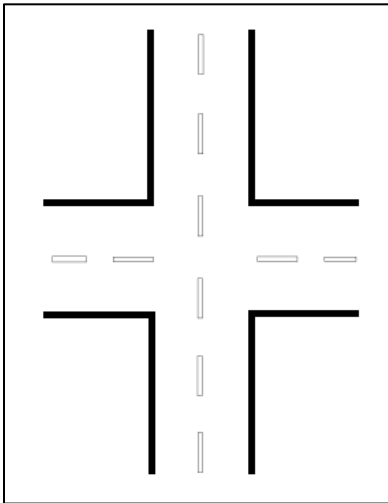
Describe the damage to the other vehicle (if applicable): _____

_____ Was the vehicle towed? ☐ Yes ☐ No

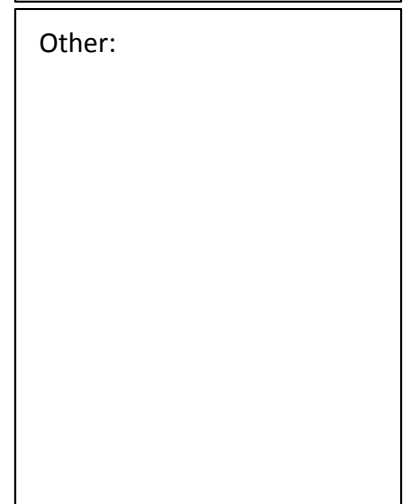
Was the accident/incident reported to the local Police Department? ☐ Yes ☐ No

If yes, who was the responding Officer? _____

Please diagram the accident, indicating streets, street signs, the direction of north and clearly labeling the vehicles involved.



Other:



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.