



City of Miami

SUPERVISOR'S REPORT OF VEHICLE ACCIDENT

INSTRUCTIONS:

1. Call the Claims Network at 1-877-647-4545 to report the accident within 24 hours of the incident.
2. Use this form to report vehicle accidents and accidents/incidents resulting in personal injury and/or property damage.
3. If accident resulted in injury to employee, complete a Supervisor's Report of Employee Accident/Injury Form.
4. An estimate of damages for vehicles must be sent to Gallagher Bassett Services within 5 days.

Accident Location	Date of Accident (MM/DD/YYYY):	Date Reported (MM/DD/YYYY):	Road Conditions: <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Other, Describe:		
	Exact Location/Address:			Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Category of Accident: <input type="checkbox"/> Backing Up <input type="checkbox"/> Making a Turn <input type="checkbox"/> Lane Change <input type="checkbox"/> Head on Collision <input type="checkbox"/> Sideswipe <input type="checkbox"/> Making a U-turn <input type="checkbox"/> Rear-end Collision <input type="checkbox"/> Other:				
Information of Driver of City Vehicle	Driver's Name: (include middle initial)		Department/Division:		
	Driver's License #:	D.O.B. (MM/DD/YYYY):	Passengers injured? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Were passengers in vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list names:				
	List type of injury/body part(s) involved (if known):				
	Transported to medical facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list medical facility and means of transportation:				
Property Damage Information		Check what type of property allegedly was damaged: <input type="checkbox"/> Automobile <input type="checkbox"/> Building <input type="checkbox"/> Fences <input type="checkbox"/> Landscaping <input type="checkbox"/> Vehicle <input type="checkbox"/> Other:			
Other Party(s) Involved Information	Driver's Name: (include middle initial)				
	Driver injured? <input type="checkbox"/> YES <input type="checkbox"/> NO	Daytime Phone:		Evening Phone:	
	Were passengers in vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list names:				
	List type of injury/body part(s) involved (if known):				
	Transported to medical facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list medical facility and means of transportation:				
	Accident investigated by a law enforcement agency? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list agency name:				
	Were photographs taken at the scene? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, by whom?				
Witness Information		Name of Witness(s)		Phone:	
Home Address(s):		City:		State:	Zip:
Description of the accident/incident (state only the facts):					
Mode of service at time of accident: <input type="checkbox"/> Emergency Response <input type="checkbox"/> Parked <input type="checkbox"/> Routing Driving <input type="checkbox"/> Backing			Devices in Use: <input type="checkbox"/> Visual <input type="checkbox"/> Audible <input type="checkbox"/> None <input type="checkbox"/> Lights <input type="checkbox"/> N/A		
Accident Details					
Please complete this diagram. Indicate names of the streets, direction, position of vehicles and point of contact. Use a solid line to show path before the accident and a dotted line to show the path after the accident. Use the symbols of the legend to recreate the scene.					
SYMBOLS/LEGEND: C City Vehicle O Other Vehicle Stop Sign Yield Sign Stop Light X Pedestrian					
			<p>Indicate the appropriate letter(s) for damaged areas on vehicle diagram (C=City Vehicle O=Other Vehicle)</p>		
<p>Scope of Employee Responsibility Statement As the driver of the City of Miami owned vehicle described in this report, I acknowledge that all information provided to the supervisor is true and correct to the best of my knowledge.</p> <p>Signature of Driver Required _____ Date _____/_____/20</p>			<p>Scope of Supervisor Responsibility Statement As the supervisor of this position, I affirm that the individual named driver was operating the vehicle within his or her authorized scope of employment at the time of the accident.</p> <p>Signature of Supervisor Required _____ Date _____/_____/20</p>		
Was the claims network above notified/contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, person notified:					
Time Notified: <input type="checkbox"/> AM <input type="checkbox"/> PM			Date Notified (MM/DD/YYYY):		
Report Prepared By (print name) _____		Title _____		Signature _____	
				Date _____/_____/20	
Supervisor (print name) _____		Title _____		Signature _____	
				Date _____/_____/20	
Report Reviewed By (print name) _____		Title _____		Signature _____	
				Date _____/_____/20	