

DHR INITIAL VEHICLE ACCIDENT REPORTING FORM

DOAS Contacted (404)463-7490 Yes No DOAS Incident Number _____

DHR Vehicle # _____ Make/Model of DHR Vehicle _____

Vehicle VIN # _____ DHR Tag # _____

Date of Accident _____ Time of Accident _____

Police Accident Report Completed? Yes No

Date & Time Police Notified of Accident _____

Location of accident _____

Who was at fault? Driver of DHR vehicle Driver of other vehicle Not Applicable

Details of Accident _____

Witness(es)? _____

Describe the Damage to DHR vehicle _____

Was any vehicle towed? Yes DHR vehicle Yes other vehicle No vehicle was towed
Where were the vehicles towed (if any)? _____

Was medical attention given? Yes No
If yes, what type of injuries? _____

Drivers' Information	Driver of DHR Vehicle	Driver of Other Vehicle
Name		
Address		
Phone Number		
Make/Model/Color of Vehicle		
Insurance Co.		
Insurance Co Phone #		
Policy Number		

Signature of Person Completing this Form _____

Contact Telephone Number _____

Agency Name _____

Agency Address _____

Type of Agency DHR Human Service Provider Private Provider (non-DHR Insured Vehicle)

Please fax to DHR Risk Management (Charlene Reid) at (404) 657-6215

NOTE: Submitting this form only meets DHR's immediate notification requirement. Risk Management must receive a copy of the Police Report and Supervisor's Accident Report within 7 days of the accident.

FOR RISK MANAGEMENT USE ONLY			
<input type="checkbox"/> Copy faxed to RTO	<input type="checkbox"/> Follow-up made with HSP	<input type="checkbox"/> Police Report Received	<input type="checkbox"/> Supv. Report Received



SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

1. Program Name _____ Telephone No. _____
 Address: _____ City _____ County _____ Zip _____

2. Name of Driver _____ M _____ F _____ Age _____
 Address: _____ City _____ State _____ Zip _____
 Job Title or Occupation _____ How Long of This Job _____

3. Date reported to Liability Insurer (Telephone Report No. 1) _____

4. Describe fully how accident happened: what was purpose of trip, how many passengers, describe damages or injuries; complete Form DPS-523 Vehicle Accident Reporting Form and attach _____

5. Date Workers Compensation First Report of Injury [Ga. Form WC1 (Rev. 12-82)] mailed _____

6. Number of non-employee passengers injured _____

7. What caused accident or loss: Give contributing factors; Backing, slippery surface, failure to use safety equipment; theft, equipment failure, driving too fast for conditions; following too close, etc. _____

8. Date theft loss or vehicle damage reported (Telephone Report No. 2) _____

9. Cost of theft loss replacement or damage repair to State Vehicle: Estimated: _____

10. What action has been taken to avoid a recurrence: If none, Why? _____

11. Describe corrective actin recommended which is beyond your authority: _____

12. Date of accident, injury or loss _____ Date of Report _____

13. Report completed by: _____ Title _____
 Telephone No. _____

PERSONAL REPORT OF ACCIDENT

This form should be completed when a traffic accident occurs and a law enforcement officer is not called to make a report. This report is for your personal use and should not be mailed to the Department of Public Safety, as it will be destroyed upon receipt.

INSTRUCTIONS:

1. Answer all questions to the best of your knowledge. If unable to answer any questions, mark "not known".
2. Give exact time of accident (date, day and hour).
3. Under "Location of Accident" show sufficient information to locate exact scene of the accident.
4. Print or type all names and addresses.
5. Sign the report in the space provided on the reverse side.
6. Report must be complete as to exact names, birth dates, and drivers license numbers.
7. Use a second report form or a sheet of plain paper of the same size to report additional vehicles, injured persons, or witnesses, or any other information for which there is insufficient space.

TIME	Date of Accident _____ Day of Week _____ Hour _____ A.M. _____ P.M. _____ Weather _____		Clear, raining, fog, etc.																			
L O C A T I O N	Place Where Accident Occurred		DO NOT WRITE IN THIS SPACE																			
	County _____ City or Township _____																					
	If accident was outside city limits, indicate distance from nearest town. Use two distances and two directions if necessary.																					
	<table style="width: 100%; border: none;"> <tr> <td style="font-size: 2em; vertical-align: middle;">{</td> <td style="text-align: center;">_____ miles _____ south-north</td> <td style="font-size: 2em; vertical-align: middle;">}</td> <td style="text-align: center;">of</td> <td style="font-size: 2em; vertical-align: middle;">{</td> <td style="text-align: center;">_____ limits of _____ _____ center of _____</td> <td style="font-size: 2em; vertical-align: middle;">}</td> <td style="text-align: center;">_____ City or Town</td> </tr> <tr> <td style="font-size: 2em; vertical-align: middle;">{</td> <td style="text-align: center;">_____ miles _____ east-west</td> <td style="font-size: 2em; vertical-align: middle;">}</td> <td></td> <td style="font-size: 2em; vertical-align: middle;">{</td> <td style="text-align: center;">_____ feet _____ south-north</td> <td style="font-size: 2em; vertical-align: middle;">}</td> <td style="text-align: center;">of</td> <td style="font-size: 2em; vertical-align: middle;">{</td> <td style="text-align: center;">_____ feet _____ east-west</td> <td style="font-size: 2em; vertical-align: middle;">}</td> <td style="text-align: center;">of</td> <td style="text-align: center;">_____ City or Town</td> </tr> </table>			{	_____ miles _____ south-north	}	of	{	_____ limits of _____ _____ center of _____	}	_____ City or Town	{	_____ miles _____ east-west	}		{	_____ feet _____ south-north	}	of	{	_____ feet _____ east-west	}
{	_____ miles _____ south-north	}	of	{	_____ limits of _____ _____ center of _____	}	_____ City or Town															
{	_____ miles _____ east-west	}		{	_____ feet _____ south-north	}	of	{	_____ feet _____ east-west	}	of	_____ City or Town										
Road Accident Occurred on: _____ <i>Give name of street or highway number, (U.S. or State). If no highway number, identify by name.</i>																						
V E H I C L E S	Your Vehicle No. 1		Approximate cost to repair vehicle \$ _____																			
	Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____	Vehicle License Plate _____	Year _____ State _____ Number _____																			
	Driver _____ <i>Print or type full name</i>		Street or R.F.D. _____ City and State _____																			
	Driver's Occupation _____ <i>Carpenter, Sales Clerk, Etc.</i>	Driver's License _____ State _____ Number _____	Driver's Birth Date _____ Mo. Day Yr.	Age _____ Sex _____																		
	Owner _____ <i>Print or type full name</i>		Street or R.F.D. _____ City and State _____																			
	Parts of vehicle damaged _____		DRIVABLE: Yes <input type="checkbox"/> No <input type="checkbox"/>	Owner's Driver's License Yes <input type="checkbox"/> No <input type="checkbox"/>																		
	Is this vehicle covered by automobile liability insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		If vehicle is not covered, did driver have liability policy applicable? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
	Name _____ <i>Show name of insurance company - not name of insurance agency</i>		Address _____ City _____ State _____																			
	Policy Number _____		Birth Date _____ Mo. Day Yr.																			
	IF YES TO EITHER, SHOW NAME OF INSURANCE CO. _____		Show policy number here _____																			
S p a c e f o r a n y t h i r d v e h i c l e o n r e v e r s e s i d e. T o t a l v e h i c l e s i n v o l v e d:	Other Vehicle No. 2		Approximate cost to repair vehicle \$ _____																			
	Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____	Vehicle License Plate _____	Year _____ State _____ Number _____																			
	Driver _____ <i>Print or type full name</i>		Street or R.F.D. _____ City and State _____																			
	Driver's Occupation _____ <i>Carpenter, Sales Clerk, Etc.</i>	Driver's License _____ State _____ Number _____	Driver's Birth Date _____ Mo. Day Yr.	Age _____ Sex _____																		
	Owner _____ <i>Print or type full name</i>		Street or R.F.D. _____ City and State _____																			
	Parts of vehicle damaged _____		DRIVEABLE: Yes <input type="checkbox"/> No <input type="checkbox"/>	Owner's Driver's License Yes <input type="checkbox"/> No <input type="checkbox"/>																		
	Is this vehicle covered by automobile liability insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		State _____ Number _____																			
	IF YES, SHOW NAME OF INSURANCE CO. _____		_____																			
	DAMAGE TO PROPERTY OTHER THAN VEHICLE _____		Approximate cost to repair \$ _____																			
	Name and address of Owner of damaged property _____		Name object and state nature of damage _____																			

Complete Both Sides of This Form

Complete Both Sides of This Form

3rd V E H I C L E	Vehicle No. 3 (If third vehicle involved)			Vehicle License Plate			Approximate cost to repair vehicle \$				
	Year	Make	Type (sedan, truck, taxi, bus, etc.)	Year	State	Number					
	Driver Print or type full name			Street or R.F.D.			City and State				
	Driver's Occupation Carpenter, Sales Clerk, Etc.			Driver's License State Number			Driver's Birth Date Mo. Day Yr.				
	Owner Print or type full name			Street or R.F.D.			City and State				
							Birth Date Mo. Day Yr.				
	Parts of vehicle damaged						DRIVEABLE: Yes <input type="checkbox"/> No <input type="checkbox"/>		Owner's Driver's License		
	Is this vehicle covered by automobile liability insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>								State Number		
	IF YES, SHOW NAME OF INSURANCE CO. _____										
	I N J U R E D	<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Specify other _____						In vehicle No. _____			
Name _____						Address _____					
Age _____		Sex _____		Race _____		Injured taken to _____		Did injured die? _____			
Nature and extent of injuries _____						Attending Doctor _____					
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Specify other _____						In vehicle No. _____					
Name _____						Address _____					
Age _____		Sex _____		Race _____		Injured taken to _____		Did injured die? _____			
Nature and extent of injuries _____						Attending Doctor _____					
Total Injured _____											
Light Conditions			What Pedestrian Was Doing								
<input type="checkbox"/> Daylight			Pedestrian was going <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Across or into _____ From _____ To _____ (check one) N S E W (Street name, highway no.) (N.E. corner to S.E. corner, or west side to east side, etc.)								
<input type="checkbox"/> Dawn or Dusk			<input type="checkbox"/> Crossing or entering at intersection		<input type="checkbox"/> Walking in roadway – with traffic		<input type="checkbox"/> Pushing or working on vehicle		<input type="checkbox"/> Other in roadway		
<input type="checkbox"/> Darkness			<input type="checkbox"/> Crossing or entering not at intersection		<input type="checkbox"/> Walking I roadway – against traffic		<input type="checkbox"/> Other working in roadway		<input type="checkbox"/> Not in roadway		
			<input type="checkbox"/> Getting on or off vehicle		<input type="checkbox"/> Standing in roadway		<input type="checkbox"/> Playing in roadway				
What Drivers Intended To Do: (Check one for each driver)											
Driver 1 2 3			Driver 1 2 3			Driver 1 2 3			Driver 1 2 3		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Go straight ahead			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make left turn			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start in traffic			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain stopped in traffic lane		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overtake and pass			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make U turn			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start from parked position			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain parked		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make right turn			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow or stop			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Get out of parked or stopped vehicle		
Witnesses											
Name _____			Address _____			Age _____			approximate		
Name _____			Address _____			Age _____			approximate		
DESCRIBE WHAT HAPPENED: Refer to vehicles by number. If more space is needed, use another report form or a sheet of plain paper of the same size.											
SIGNATURE _____			ADDRESS _____			DATE _____			Signature of person submitting report is required – complete both sides of this form		