

**DOUGHERTY COUNTY SCHOOL SYSTEM
SAFETY DEPARTMENT**

Fleet Accident Report

(Please forward this report to the Director of Safety within 2 days following an accident)

To Be Completed By Driver of DCSS Vehicle:

Accident Date:		Accident Time:		Accident Location:	
Name of Operator:			Title:		Age:
Home Address:			City:		State/Zip:
Home Phone #:		Work Phone #:		Work Location:	
Driver's License #:		SSN:		Class:	Expiration Date:
Vehicle #:		Tag#:		Make/Model:	
Year:		Type of Vehicle: (check one)		Other:	
		School Bus		Auto	
		Mower		Trailer	
		Van		Pickup	
		Heavy Equipment		Tractor	
		Utility Body			
Damage To System Vehicle: (check one)		None		Light	
		Moderate		Heavy	
Weather:	Clear	Cloudy	Rain	Fog	Snow
	Sleet	Ice			
Traffic:	Light		Moderate		Heavy
911 Called?	Yes	No	Police Called?	Yes	No
			Supervisor Called?	Yes	No
Number of Passengers In System Vehicle?		Number of Injured In System Vehicle?		Name of System Personnel Injured:	
Was injured transported to hospital? Yes No		How?		What hospital?	
1. Describe how the accident happened.					
2. What was the primary cause of the accident?					
3. What could you have reasonably done to prevent this accident?					
4. What could be done to prevent similar accidents in the future?					
5. Was the driver on duty at the time of the accident?				Yes	No
6. Did the weather or road conditions contribute to this accident?				Yes	No
7. Were the driver/passengers wearing seat belts at the time of the accident?				Driver:	Passenger

To Be Completed By DCSS Supervisor Authorized To Investigate Accidents:

Name:		Title:		Date of Investigation:	
1. Were pictures taken?	System Vehicle:	Yes	No	Other Vehicle:	Yes No
2. What time were you called?			What time did you arrive at the scene?		
3. Was alcohol and/or drug testing required for the driver of the system vehicle (CDL)? Yes No					
4. Had vehicle(s) been moved from the original scene of the accident when you arrived? Yes No					
If yes, by whose authority? Name:		Title:			
5. Do you feel that further driver (system) action could have prevented this accident? Yes No					
Comments:					

6. Other Vehicle(s) Involved In Accident:

A. Name:	Address:	Home Ph #:	Work Ph #:
Type of Vehicle:	Make:	Year:	Tag#:
Damage To Vehicle: None Light Moderate Heavy		Any old damages? Yes No	
		If yes, location:	
Number of passengers in vehicle?		Number of occupants injured in vehicle?	
B. Name:	Address:	Home Ph #:	Work Ph #:
Type of Vehicle:	Make:	Year:	Tag#:
Damage To Vehicle: None Light Moderate Heavy		Any old damages? Yes No	
		If yes, location:	
Number of passengers in vehicle?		Number of occupants injured in vehicle?	

Comments:

Recommendation:

To Be Completed By Driver's Immediate Supervisor: (Optional)

Name:		Title:		Department:		Date:	
Has driver been involved in previous accident while driving a system vehicle? Yes No							
Date:	Class:	Points Accessed:	Date:	Class:	Points Accessed:		
Date:	Class:	Points Accessed:	Date:	Class:	Points Accessed:		

Comments:

Recommendation: