



HOPE ENTERPRISES, INC.

VEHICLE ACCIDENT/CLAIM REPORT

IN CASE OF ACCIDENT:

- 1. When conditions permit, move onto roadway shoulder to prevent further damage/hazards. Turn on hazard flashers. Place warning reflectors outside promptly if no individuals are on the vehicle.
2. Call/ask someone to summon police, and medical assistance if anyone is injured. Repeat after 5 minutes.
3. Keep calm. Be courteous. Do not argue. Do not accept responsibility at the scene. Make no statement concerning the accident to anyone except a police officer.
4. Complete as much information as possible on this report on the scene.
5. Obtain the names and addresses of all persons injured, regardless of how minor the injury, and any witnesses (police will frequently secure this & provide a report # for your insurance company to acquire). Try to learn where injured parties are treated.
6. Obtain the other party's insurance company name, policy number and insurance agent's name and telephone number.
7. Before leaving accident scene, check to see that you have all the facts.

Complete and deliver this report to your supervisor within 24 hours of the incident or accident. Injuries requiring medical treatment for a driver or individual served require an immediate oral report to the appropriate clerical person and program supervisor before completion of this form.

ACCIDENT: Any collision of an agency vehicle with an object or another vehicle, regardless of whether damage results to any vehicle or its occupants

INCIDENT: An occurrence which is unique, out of the ordinary, and does not occur in the daily routine that could have resulted in an auto accident, which could be a hazard, present or future.

THIS IS CONSIDERED AN [] ACCIDENT [] INCIDENT

THIS REPORT [] IS [] IS NOT SUPPLEMENTAL TO AN INCIDENT, INDIVIDUAL INJURY, EMPLOYEE ACCIDENT, OR PROPERTY DAMAGE REPORT(S)

Route for Signature:

Program Spvsr/Production Mgr/Habilitation Mgr
Program Director

Director HR & Administration/Risk Manager

Claim Filed [] Hope's Auto Insurance Carrier - Claim #

Date Claim Rep Telephone

Date [] Other's Auto Insurance Carrier - Claim #

Contact Info

Date [] Neither - Claim under \$1,000 deductible

Initials Original forwarded for signature & return to Risk Manager

Vice President/President

Safety Committee Chairman

HOPE ENTERPRISES, INC. VEHICLE

Form containing fields for driver information, accident details, witnesses, and damage to other vehicle.

DAMAGE TO OTHER VEHICLE

Form containing fields for other driver's information and damage to other vehicle.

	Insurance Co. Name	Phone
	Insurance Agent's Name	
	Insurance Policy No.	
	Comments made by other driver	

Was there property damage other than to a vehicle (for example, broken fence, telephone pole, etc.)? Yes No If yes, describe location, and property owner's name, address and telephone number. If Hope property was damaged, file a Property Damage-Loss Report.

STAFF AND INDIVIDUALS INJURED IN HOPE'S VEHICLE (attach Incident/Accident report to describe injuries)

Name _____ Address: _____
 Telephone No. _____
 Hope Program: _____ If this is a non-Residential Services individual, does his or her family have auto insurance? Yes No

Name _____ Address: _____
 Telephone No. _____
 Hope Program: _____ If this is a non-Residential Services individual, does his or her family have auto insurance? Yes No

Name _____ Address: _____
 Telephone No. _____
 Hope Program: _____ If this is a non-Residential Services individual, does his or her family have auto insurance? Yes No

Name _____ Address: _____
 Telephone No. _____
 Hope Program: _____ If this is a non-Residential Services individual, does his or her family have auto insurance? Yes No

Name _____ Address: _____
 Telephone No. _____
 Hope Program: _____ If this is a non-Residential Services individual, does his or her family have auto insurance? Yes No

PASSENGERS IN OTHER VEHICLE – INJURED OR NOT INJURED

Name _____ Address: _____
 Telephone No. _____

Name _____ Address: _____
 Telephone No. _____

Name _____ Address: _____
 Telephone No. _____

Person(s) Notified _____ When _____ By Whom _____
 _____ When _____ By Whom _____

Signature of Staff Person Completing this Report (a witness if possible)	
Date of Report:	Title:

- Fully completed original to Safety Committee Recording Secretary – Logged on _____ for Annual Safety Report
- Secretary copies for Safety Committee Records & Incident Review – Copied on _____
- Secretary forwards original to Director HR & Administration./Risk Manager

AUTOMOBILE CLAIM FILE	SAFETY COMMITTEE REVIEW
Damage over \$750 requires two estimates	Could this accident have been prevented? Suggestions discussed for measures to

Repair estimates received from	Amount	implement to prevent a recurrence of accident.
		Was immediate action taken to correct any unsafe condition? What, when and by whom?
Claim contact notes		
Final disposition		
		Final disposition, future action warranted additional comments, etc.
Cc: Accounting Department		

ADD ADDITIONAL PAGES TO THIS REPORT IF NECESSARY