Email

AGENCY VEHICLE ACCIDENT REPORT FORM

(See Vehicle Accident Procedures Form located in each vehicle)

Paladin Auto Policy #: **S 17364000**	Insurance: Selective Insurance Company

Print Drivers Name:	Date of Accident/Incident
Vehicle VIN# (last 5 digits only)	Make/Model)

A. Where did Accident/Incident Occur (complete address)

B. Name of clients/passengers on vehicle (list all). **Complete all sections below**

Name of passenger	List injury (if known)	None Known	Treatment Yes/No	By staff or list where

Use other side of form if more individuals on vehicle

Signature of Driver	Date Signed

C. Explain the circumstances that led to the accident-be specific. (Attach a copy of the police report or provide accident number given to you by Police Officer.

Note: If injury, complete an ACCIDENT/INJURY FORM FOR EACH INDIVIDUAL on the vehicle. FOR YOUR INFORMATION: Workers' Comp. Insurance Company: Accident Fund

Distribution of completed form: Human Resource Manager and Operations Officer for filing and distribution in house.
CC: Transportation Manager and Corporate Compliance Officer

ACCIDENT REVIEW:

Date Reviewed	**Recommendations/Results:**

NOTE: IF THERE IS AN INJURY REQUIRING TREATMENT AT WORKERS' COMP. FACILITY, A WORKERS' COMPENSATION REPORT FORM MUST ALSO BE COMPLETED WITHIN ONE DAY IF INCIDENT. (Rule of Thumb: If dollars are involved, must complete the form. Administration will report the accident/illness to the carrier.

Revised 8/2, 4/5, 2/14, 12/14, 9/17, 4/22