Employee Accident Statement Form

DATE:_____TIME:_____AM/PM Day of week: Pick day

Location of the accident: _____

Employee Instructions: This form will be utilized by employees to document everything that occurred in the accident. Employees should provide as much detail as possible (Use the reverse side if necessary). Include a sketch of the accident scene. Identify anyone that may have been involved in the accident or witnessed the accident. If you were backing up and someone was ground guiding you, please identify by name your ground guide. **IMPORTANT: Employees may complete this form and turn it into their Supervisor or Accident Investigator. You have twenty-four (24) hours to complete this form**. Supervisors will immediately turn this form Risk Manager. RM@marionsc.org

Name:_____ SSN: _XX__-_XX__-_____

Department:_____

Address:_____ City:_____ State:_____

County Vehicle #:_____ Model:_____ Year:_____

Provide as much detail as possible, (names, addresses, vehicle descriptions, sketches, etc.).

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