

AUTOMOBILE LOSS REPORT

(Use this form to report incidents involving County automobiles. Also, see the forms and instructions in the "Injury Management Guidelines" at www.warrencountyny.gov/insurance.)

NAME OF INSURED: WARREN COUNTY

DATE OF ACCIDENT: _____ TIME: _____ LOCATION: _____

COUNTY VEHICLE (YR & MAKE): _____ VIN# _____

PRESENT LOCATION OF VEHICLE: _____

OPERATOR OF COUNTY VEHICLE: _____ PHONE: _____ AGE: _____

OPERATORS ADDRESS: _____

DESCRIPTION OF ACCIDENT: _____

AREA OF DAMAGE ON COUNTY VEHICLE: _____

OTHER VEHICLE

OTHER VEHICLE (YR & MAKE): _____ PLATE #: _____

OWNER(NAME, ADDRESS, PHONE): _____

DRIVER (NAME, ADDRESS, PHONE): _____

OTHER AGENT OR INSURANCE CO (NAME, ADDRESS, PHONE): _____

AREA OF DAMAGE ON OTHER VEHICLE: _____

INJURIES

NAME: _____ AGE: _____ PHONE: _____

ADDRESS: _____

INJURY: _____

NAME: _____ AGE: _____ PHONE: _____

ADDRESS: _____

INJURY: _____

WITNESSES (All witnesses complete appendix C attached)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

POLICE DEPT: _____ TICKETS ISSUED: _____

OTHER COMMENTS: _____

REPORT COMPLETED BY: _____ DATE: _____

CONTACT PHONE NUMBER: _____

Department supervisor should immediately fax this form to the County Attorney at 761-6377 and mail the original to the County Attorney. Department should also fax this form to Self-Insurance at 761-6249. (If County Employee was injured, see procedure to report employee injuries at www.warrencountyny.gov/insurance.)

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249

email: warrencountyinsurance@co.warren.ny.us

Supervisor's Report of Accident Investigation (Appendix D) Supplement to C2 Form

(To be completed immediately. This form does not replace Worker's Compensation forms. Established procedures for Worker's Compensation reporting must continue to be followed.)

Date of Investigation:	Investigator:
Injured Person:	

Describe the accident in detail (include physical surroundings, equipment in use)

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

<ul style="list-style-type: none">• Improper lifting, carrying, handling• Improper use of tools or equipment• Operating without authority• Failure to wear personal protective equipment• Failure to use safety devices• Failure to use proper tools/equipment• Failure to obey rules/procedures• Failure to secure ladders• Lack of adequate training	<ul style="list-style-type: none">• Transitioning to/from ladder• Misstep on ladder• Over-reaching on ladder• Using defective equipment• Overriding safety devices• Horseplay• Taking shortcuts or hurrying• Action of others• Other: _____
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Unsafe Conditions:

<ul style="list-style-type: none">• Wet and/or slippery working surface• Defective floor and/or walking area• Congested work area• Poor housekeeping• Inadequate lighting• Inadequate guards• Inadequate design or maintenance	<ul style="list-style-type: none">• Lack of available personal protective equip• Lack of proper tools or equipment• Defective tools or equipment• Inadequate warning system• Projection hazards• Hazardous atmosphere• Other: _____
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**Supervisor's Report of Accident Investigation (Appendix D)
Supplement to C2 Form - Page 2**

Personal Factors:

- | | |
|---|---|
| <ul style="list-style-type: none">• Improper work habits• Unaware of work hazard• Improper motivation | <ul style="list-style-type: none">• Improper attire• Improper attitude• Unwilling to follow work rules• Other: _____ |
|---|---|

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

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Accident Investigation Witness Statement (Appendix C)

Personal Information

Name of Witness			
Address			
City, State, Zip			
Phone			

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information - Injured Person's Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

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How did the Injury Occur?

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How Could the Accident Have Been Prevented?

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Signed:

Witness Name		Date	
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