ACCIDENT, EMERGENCY, VANDALISM, DAMAGE REPORT

***Please notify the Insurance Department at (432) 498 – 4011 when an accident occurs.***

*\*\*\*This is a fillable form. Click on each underlined item and type the requested information. Then hit tab and proceed to the next underlined*

 *item. If you see this symbol ⏷ click on ⏷. When completed you may save the document and submit to submit to Insurance Coordinator*

 *Mikala Haiduk by printing document and mailing in Inter-Departmental Envelope or you may email to:* *Mikala.Haiduk@ectorcountytx.gov*

Department: Choose an item. Date of Accident: Click here to enter a date.

Date of this Report: Click here to enter a date.

**ACCIDENT VICTIM**

#1 Injured Person

Last Name: Enter Last Name First Name: Enter First Name

Time Accident Occurred: Enter Time of Day

Address of Injured Person: Enter Address Telephone Number: Enter Telephone Number

Sex: Choose an item. Date of Birth: Enter DOB

If DOB Unknown indicate Approximate Age: Enter Approximate Age

Name of Insurance Carrier: Enter Name of Insurance Carrier

Whom Notified: Enter Name of Individual whom you notified of Accident

Nature of Incident: Choose an item.

Detailed Description of Incident:

Enter Detailed Description of the Incident

#2 Injured Person

Last Name: Enter Last Name First Name: Enter First Name

Time Accident Occurred: Enter Time of Day

Address of Injured Person: Enter Address Telephone Number: Enter Telephone Number

Sex: Choose an item. Date of Birth: Enter DOB

If DOB Unknown indicate Approximate Age: Enter Approximate Age

Name of Insurance Carrier: Enter Name of Insurance Carrier

Whom Notified: Enter Name of Individual whom you notified of Accident

Nature of Incident: Choose an item.

Detailed Description of Accident:

Enter Detailed Description of Accident

Please select Name of Agency (s) notified: Choose an item.

If you selected Other Please provide details below:

Enter Details

If EMS reported to site, did Injured Party accept transport to a Medical Facility? Choose an item.

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Signature of Injured Party or Guardian Printed Name of Injured Party or Guardian

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Signature of Staff Member who Witnessed or can confirm Injured Party Declined EMS Transport to Medical Facility

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Signature of Staff Member Handling Incident

***\*\*\*Please note that if Insured accepts transport to a medical facility, Ector County is not responsible for cost of transport***.