



ACCOMACK COUNTY ACCIDENT REPORT

If this is an injury of an employee, please call Company Nurse. 1-888-770-0925 code: V001	
Please complete form and attach a brief statement describing the accident from each employee involved.	
Department:	Date of Loss:
Type of Damage (please check): Auto Property General Liability	Date of Accident:
	Time of Accident:
Employee(s) Involved:	Names of Witnesses and Phone Numbers:
Location of Accident:	Description of Accident (attach a diagram and/or photos, if needed):
What could have been done to avoid this accident? (The assumption is that all accidents are avoidable.)	

Auto

Additional Information Needed for Insurance Purposes:			
For Auto Accidents	Vehicle Year:	Vehicle Make:	Vehicle Model:
VIN # (last four):	Describe Damage:		
Estimate Amount? (If YES, attach two estimates)	Y or N	Driver's Name	
Third Party Info (if another vehicle is involved)	Vehicle Year:	Vehicle Make:	Vehicle Model:
Owner's Name, Address, and Phone Number:		Owner's Insurance Carrier and Policy Number:	
Describe Damage:			Estimate Amount:
Names, Addresses, and Phone Numbers of Persons Injured:			

Property

For Property Claims	Type of Claim (please check) Fire Lightning Flood Wind Hail Theft Other	Probable Amount of Loss:	Description of Loss and Damage:
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Liability

For General Liability Claims	Location of Occurrence (full address):	Description of Loss and Damage:
Third Party Injury/Property Damage Information	Name, Address, and Phone Numbers of Person(s) Injured and/or Owner of Property Damaged:	
Description of Injury or Property Damage:		