VEHICLE COLLISION REVIEW
RISK MANAGEMENT WORK SHEET

COLLISION DATE:_____ COLLISION TIME:_____ MONTH:_____

EMPLOYEE NAME:_____ DEPART:_____

COLLISION TYPE:

1= Head On	5=Struck Parked Car	9 = Side Swiped
2 = Rear Ended	6 = Struck w/Parked	10 = Intersection Straight
3 = Rear End	7 = Struck w/Stopped	11 = Intersection R/L Turn
4 = Backing	8 = Struck Fixed Object	12 = Struck Pedestrian/Animal

INJURIES: Y____N_____ DESTINATION:_____

VEHICLE NO: _____

DESCRIBE RESULT OF ACCIDENT (Accident/Injury/Property/Equipment)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DESCRIBE INDIRECT CAUSES

UNSAFE CONDITIONS: (Did unsafe conditions exist at the time of the incident?)

_____
_____
_____
_____

UNSAFE ACTS: (Where their unsafe actions displayed by the employee or others?)

_____
_____
_____
_____

INCIDENT CAUSE IDENTIFICATION

PREVENTABLE:

_____
_____
_____
_____

NON-PREVENTABLE:

_____
_____
_____
_____

RECOMMENDATIONS FOR FUTURE PREVENTION

_____
_____
_____
_____
_____

SIGNATURE OF SAFETY COMMITTEE: _____ DATE: _____