

**MANHEIM'S GREATER AUTO AUCTION PHOENIX
Accident Investigation Report**

Location of Accident _____ Accident Report Number _____

Date/time of Accident _____ Injury: _____ yes _____ no

Name of Driver(s)/Injured Person(s): _____

Job Title _____ Department _____
(If more space is needed for any item, please continue on additional sheet.)

Nature of Injury _____

Description of the Accident (Use diagram on back if a vehicle is involved) (Include witnesses, if any) _____

Describe any treatment provided _____

Was the accident caused by an unsafe act? _____ Explain _____

Was the accident caused by an unsafe condition? _____ Explain _____

Have similar accidents occurred before? _____ Explain _____

What actions have/will be taken to prevent a recurrence? _____

Who is responsible for corrective action? _____

When will corrective action be completed? _____

For Safety Office Use Only	Date	Initials
A Third Party is involved and a file has been established	_____	_____
Drug Screen Results have been received and reviewed	_____	_____
A Workers Compensation Report has been called in	_____	_____
Appropriate documents have been placed in the Med File	_____	_____
OSHA 300 Report has been updated as necessary	_____	_____
Temporary Services Agency has been notified	_____	_____
Accident Review Board action	_____	_____
(If an ARB citation was issued is a copy in the personnel file?)	_____	_____
If off the Lot, was a citation issued? _____ To whom? _____		
Nature of the citation: _____		

Accident involving one or more vehicles

Vehicle #1
Year _____ Make _____ Model _____ Color _____ VIN _____
Driver _____ Department _____ Job Title _____
Driver's License # _____ State _____ Exp Date _____
Damage to vehicle #1 _____

Vehicle #2
Year _____ Make _____ Model _____ Color _____ VIN _____
Driver _____ Department _____ Job Title _____
Driver's License # _____ State _____ Exp Date _____
Damage to vehicle #2 _____

Diagram of the Accident
Identify location of accident: _____



Completed by: _____
Name/Signature Title

Date of Report: _____ Sent for Drug screen: _____

Reviewed by Department Manager _____
Name/Signature Date

Reviewed by Accident Review Board _____
Name/Signature Date

Distribution: HR, Security, AGM, Department