**ECTOR COUNTY – VEHICLE ACCIDENT INFORMATION**

\*\*\*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 Safety/Risk Management Coordinator either by printing document and mailing in Inter-Departmental Envelope or you

may email document to: [Samuel.Brijalba@ectorcountytx.gov](mailto:Samuel.Brijalba@ectorcountytx.gov)

Department: Enter Dept. Name Date of Accident: Click here to enter a date.

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

**ECTOR COUNTY EMPLOYEE**

Driver: Click her to Enter Last Name Enter First Name Enter Middle Initial Home Phone: Enter Home Phone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

Type of Vehicle: Choose an item. Unit #: Click here to Enter Unit # Make & Model: Click here to Enter Make & Model

Model Year: Click here to Enter Model Year Details of Accident & Damage: Click here to give details of accident and damage

**OTHER VEHICLE**

Driver: Enter Last Name Enter First Name Enter Middle Initial Home Phone: Enter Telephone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

Type of Vehicle: Choose an item. Make & Model: Click here to Enter Make & Model Model Yr. Click here to Enter Model Yr.

Details of Accident & Damage: Click here to give details of accident & damage

Owner of Vehicle: Enter Last Name Enter First Name Home Phone: Click here to Enter Phone Number

Name of Insurance Carrier: Enter Name of Insurance Carrier Address: Click here to Enter Street Address or P.O. Box #

City & State: Enter City & State Zip Code: Enter Zip Code Policy Number: Click here to Enter Policy Number

**INJURIES**

#1 Injured Person Choose an item. Click here to Enter Last Name Click here to Enter First Name Click here to Enter Phone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

Describe Injury: Click here to describe injury

**INJURIES**

#2 Injured Person Choose an item. Click here to Enter Last Name Click here to Enter First Name Click here to Enter Phone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

Describe Injury: Click here to describe injury

What Law Enforcement Agency reported to the scene? Choose an item. Tickets Issued? Choose an item. Who was cited? Choose an item.

**WITNESSES**

#1 Witness Click here to Enter Last Name Click here to Enter First Name Click here to Enter Phone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

#2 Witness Click here to Enter Last Name Click here to Enter Frist Name Click here to Enter Phone Number

Mailing Address: Enter Street Name or P.O. Box # City & State: Enter City & State Zip Code: Enter Zip Code

***In Case of Accident – Immediately Notify Your Immediate Supervisor & Risk Mgt. Coordinator @432.498.4025 After Hours: 432.254.3034***