



# CHEROKEE COUNTY VEHICLE ACCIDENT PACKET

## “KEEP IN GLOVE BOX”





## **CHEROKEE COUNTY VEHICLE ACCIDENT INSTRUCTIONS**

Drug and alcohol testing must be performed when any employee, while in operation of a County vehicle or while in the performance of Cherokee County business, is involved in an accident that results in: 1) a fatality; or 2) a citation issued to the employee; or 3) an injured person requiring immediate medical treatment; or (4) employees who have been determined to be at fault by the investigating law enforcement officer for damage to County property or 5) employee at fault for damage to any other property. Alcohol and drug test(s) shall be completed within 8 hours of an accident. For Non-DOT employees a 10 panel drug test is required.

\*If vehicle accident results in an injury requiring medical treatment ~ Supervisor/employee will need to complete additional Workers' Compensation forms in the WC Accident Packet on the HR website ~ [cherokeega.com/human-resources](http://cherokeega.com/human-resources).

Fire Department employees will report vehicle accidents to their Battalion Chief, who will complete the Fire Department Vehicle Accident and the Workers' Comp forms packet (if needed).

Non Fire/ES Employees will notify their immediate supervisor as soon as reasonably practical. The Supervisor will transport the employee to the nearest collection site.

### **COLLECTION SITES AND HOURS FOR TESTING**

**OPTIMAL HEALTH ~ 1030 Marietta Rd, Canton, GA 30114 ~ PH: 770-720-8668**  
Hours: 9am-1pm & 2pm-6pm ~ Mon to Fri ~ Sat/Sun **CLOSED**

**PRICE COUNSELING ~ 2920 Marietta Hwy~ Suite # 122 ~ Canton, GA 30114 ~ PH: 770-479-5501**  
Hours: 8:30am-4:30pm ~ Monday-Thursday ~ Friday 8:30AM-1:30PM ~ *Sat and Sun Closed*

**Peachtree Immediate Care ~ 720 Transit Ave Suite 101 ~ Canton GA 30114~ PH: 770-720-7000**  
*Hours: 8am~8pm ~ Monday - Sunday*

**Northside Hospital Cherokee ~ 450 Northside Cherokee Blvd ~ Canton, GA; 30114 ~ PH: 770-224-1000**  
*Hours: 24 hours~ Mon-Sun*

The employee will: 1) Complete the Vehicle Accident Report Form; 2) Cherokee County Accident Investigation Report (*if injured*); 3) Have any witness (es) complete the Witness Accident Statement as soon as possible, but no later than 24 hours after the accident; 4) Take pictures of the accident scene if possible. A Georgia Uniform Motor Vehicle Accident Report will also be required for additional information.

### **ALL OF THE ABOVE DOCUMENTS NEED TO BE SENT TO:**

Robert Alford ~ [ralford@cherokeega.com](mailto:ralford@cherokeega.com) and Matt Black ~ <mailto:rblack@cherokeega.com>  
Fire Department personnel will send documents to: Field Operations Chief ~ [bwest@cherokeega.com](mailto:bwest@cherokeega.com)



**NOTIFY THE DRIVER OF THE OTHER VEHICLE OF THE FOLLOWING**

Cherokee County is insured by One Beacon Insurance Company  
A copy of the insurance certificate should be in the vehicle glove box,  
If not ~ a copy is attached for proof of insurance

**AUTOMOBILE CLAIMS ARE HANDLED BY:**

Cherokee County BOC  
Risk Management  
1130 Bluffs Parkway  
Canton, GA 30114  
Attn: Matt Black ~ email: [rblack@cherokeega.com](mailto:rblack@cherokeega.com)  
Phone: 678-493-6033 ~ Fax: 678-493-6035



## GEORGIA INSURANCE POLICY INFORMATION CARD

INSURANCE COMPANY NAME

 COMMERCIAL     PERSONAL**OneBeacon Insurance Company**POLICY NUMBER  
7910004710007EFFECTIVE DATE  
10/01/2017EXPIRATION DATE  
10/01/2018

NAMED INSURED

**Cherokee County, acting by and through its Board of Commissioners  
1130 Bluffs Parkway  
Canton, GA 30114-5632**

VEHICLE INSURED

YEAR

MAKE/MODEL

VEHICLE IDENTIFICATION NUMBER

1

FLEET.

FLEET

SEE IMPORTANT NOTICE ON REVERSE SIDE

KEEP THIS CARD IN YOUR MOTOR  
VEHICLE WHILE IN OPERATION

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the following information:

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

The current status of actual motor vehicle liability insurance coverage is maintained by the Georgia Dept. of Revenue and is accessible to law enforcement agencies upon a check of the vehicle registration.



# VEHICLE ACCIDENT REPORT

This report is to be used by all departments to make an immediate report of all motor vehicle accidents involving county employees, vehicles or equipment. This report is NOT a substitute for the Georgia Uniform Motor Vehicle Report completed by law enforcement. This report is NOT a substitute for reporting any injury sustained in the accident.

Location of Accident: \_\_\_\_\_  
\_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Vehicle – No. 1 VIN# _____ (County Driver)	Vehicle – No. 2 License Plate# _____
Year: _____ Make: _____ Type (Sedan, Truck, etc.) _____	Year: _____ Make: _____ Type (Sedan, Truck, etc.) _____
Driver's Name _____	Driver's Name _____
Driver's Department _____ Phone Number _____	Address _____ Policy Number _____
Driver's License Number _____	Phone Number _____ Driver's License Number _____

### **EMPLOYEE STATEMENT OF ACCIDENT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Be Specific. Write street or highway names/numbers. Take Pictures if possible.* Signature \_\_\_\_\_

Did Police investigate? Yes \_\_\_ No \_\_\_ If yes- Who? City Police \_\_\_\_\_ Sheriff \_\_\_ State Patrol \_\_\_\_\_

Date of Police Report: \_\_\_\_\_ Report Number: \_\_\_\_\_ Officer Name: \_\_\_\_\_

Any Injuries Due to the Accident? Yes \_\_\_ No \_\_\_

If Yes ~ complete County Accident Investigation Report form

Name of Witness (s) \_\_\_\_\_  
\_\_\_\_\_



# Cherokee County Accident Investigation Report

Employee Name:		Employer's Premises: Yes    No Off site:                    Yes    No	Date of Accident or illness:
Job Title:		Location of Accident:	Time of Accident  AM        PM
Department:	Date Reported:	Has employee performed this job before?	
		Yes_       No	
Was any county property/equipment damaged? Yes    No		Job being performed	
Property/Equipment Damaged:			
What was employee doing when injury/illness occurred?			
Describe in detail how accident occurred?			
Part of body affected/injured? (be specific):			
Nature of injury/illness (be specific):			

**PLEASE INDICATE IF ANY OF THE FOLLOWING CONTRIBUTED TO THE INJURY OR ILLNESS**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Unsafe Act(s)             | <input type="checkbox"/> Lack of Experience | <input type="checkbox"/> Defective Tools/Equipment    |
| <input type="checkbox"/> Employee Training         | <input type="checkbox"/> Improper Lifting   | <input type="checkbox"/> Improper Procedures          |
| <input type="checkbox"/> Insufficient Maintenance  | <input type="checkbox"/> Poor Housekeeping  | <input type="checkbox"/> Improper PPE or PPE not used |
| <input type="checkbox"/> Unsafe Conditions         |   |   |
| <input type="checkbox"/> Violation of Safety Rules | Other: _____                                |   |

**RECOMMENDED CORRECTIVE ACTION:**

\_\_\_\_\_

Was Post-Accident Drug Test administered? Yes  No

Name of Hospital/Urgent Care Facility: \_\_\_\_\_

If YES ~Location: \_\_\_\_\_

If NO ~ Why? \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Person Completing Report: \_\_\_\_\_ Date \_\_\_\_\_

# ACCIDENT WITNESS STATEMENT

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**TO BE COMPLETED BY THE WITNESS ONLY!**

**Injured Employees Name:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Describe fully how accident occurred:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe Injury Sustained (be specific):**

\_\_\_\_\_  
\_\_\_\_\_

**Any Recommendations on how to prevent this accident from occurring?**

\_\_\_\_\_  
\_\_\_\_\_

**The above is factual to the best of my knowledge:**

\_\_\_\_\_  
**Name (Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

# ACCIDENT WITNESS STATEMENT- Supplemental

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**TO BE COMPLETED BY THE WITNESS(es) ONLY!**

**Injured Employees Name:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Describe fully how accident occurred:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe Injury Sustained (be specific):**

\_\_\_\_\_  
\_\_\_\_\_

**Any Recommendations on how to prevent this accident from occurring?**

\_\_\_\_\_  
\_\_\_\_\_

**The above is factual to the best of my knowledge:**

\_\_\_\_\_  
**Name (Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**



## VEHICLE ACCIDENT CHECKLIST

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- Move your vehicle to a safe location and do not obstruct traffic, if possible
- Remain calm & Turn off your engine
- Check for personal, passenger, and/or citizen injuries
- If injuries - **CALL 911**
- Use safety measures to prevent road hazards
- Aid the injured, if no immediate risk
- Take photos of all vehicle damage and the accident scene
- Use the Vehicle Accident Packet Forms
- Contact Fleet/Services in order to secure a tow (if needed) ~ 770-345-0200  
AFTER HOURS ~ 678-414-2417
- Secure any witness information - if available
- Certificate of Coverage for Insurance ~ **Insurance Company: One Beacon**
- Get a copy of the Police Report Case Number and submit it with the *Vehicle Accident Report*

**DO NOT GIVE STATEMENTS TO ANYONE, EXCEPT LAW ENFORCEMENT OFFICERS**