FORM 1

ACCIDENT REPORT

County of Galveston

For accidents involving possible injuries when non-employees are involved:

Name: ______________________________

Mailing Address: ______________________________

Evening Phone: ____________

Daytime Phone: ____________

For County Employees only:

Sex: ___ Date of Birth: ________

Marital Status: ______ No. of Dependant Children______ Spouse's name ____________

Position: ____________ Department: ____________

Was employee doing his regular job? ___ Yes ___ No, If no, explain ____________

____

Date of Injury: __________ Time of Injury: ________ a.m. p.m. Date Reported Injury: __________

Treating Doctor's Name: ____________ Address: ____________ Ph # ________

Address or Location Where Injury Occurred: ______________________________

Description of accident:

____

____

____

Describe injuries ______________________________

____

If a motor vehicle accident **attach a copy of the police accident report.** If no report was taken fill out the following information:

Your vehicle (make model year) ____________ Odometer Reading ________ License No. ________

Unit # ______ Insured by: Company ____________ Policy Number ____________

Other vehicle (make model year) ____________ Odometer Reading ________ License No. ________

Insured by: Company ____________ Policy Number ____________

Witnesses (name, address, ph.#):

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____

____

(if applicable)

Employee's Signature ____________ Date ________ Supervisor's Signature ____________ Date ________