POLICY TITLE: Employee Unusual Incident Reporting CHAPTER: General Administrative		PAGE 1 OF 7
	CHILD AND FAMILY SERVICES AGENCY Approved by:_____ Signature of Agency Director	PROFESSIONAL STANDARDS
EFFECTIVE DATE: June 28, 2011	LATEST REVISION: August 30, 2011	REVIEWED BY LEGAL COUNSEL: June 29, 2011

I. AUTHORITY	The Director of the Child and Family Services Agency (CFSA) adopts this policy to be consistent with the Agency's mission and applicable Federal and District of Columbia laws and regulations including D.C. Municipal Regulations Title VI, §1803 (Government Personnel, Employee Conduct).
II. APPLICABILITY	All employees and contractors of CFSA. However, to the extent that any provision of this policy conflicts with an applicable collective bargaining agreement, the agreement shall supersede the Policy.
III. RATIONALE	The Child and Family Services Agency provides guidance for employees and contracted personnel (hereinafter "employees") to report unusual incidents. Such incidents may include, but are not limited to, the loss of personal or CFSA property, work-involved injuries and accidents, or other events that are different from the regular routine or established procedure. Failure to report unusual incidents may present a safety risk to individuals, and may contribute to serious liability issues for CFSA. To ensure that these incidents are reported in a timely manner, for appropriate follow-up, CFSA requires employees to adhere to this policy.
IV. POLICY	It is the policy of the Child and Family Services Agency that employees report all unusual incidents immediately to the appropriate supervisor, and complete the applicable forms (Employee Unusual Incident Report Form, CFSA Information Technology Incident Report Form, Motor Vehicle Accident Form, Department of Public Works [DPW] Initial/Incident Report, and the Chain of Custody Form). Information on these forms: 1. Identifies individuals involved and/or witnessing the incident; and 2. Addresses the location of incident; type of incident; intervention/s used to resolve the incident and includes a brief description of the incident. Criminal acts or incidents that may be deemed a financial liability to CFSA, or that may present a safety risk, must be immediately reported to the Director of the Child and Family Services Agency, Deputy Directors, Office of Risk Management, Office of the Inspector General and law enforcement official.

V. CONTENTS	**A.** Definition of an Employee Unusual Incident **B.** General Procedures for Employee Unusual Incidents **C.** Role of the CFSA Office of Risk Management **D.** Role of the Administrator, Manager, and Supervisor **E.** Role of Human Resources **F.** Unusual Incidents Reports/Criminal Investigations
VI. ATTACHMENTS	**A.** Employee Unusual Incident Report Form **B.** CFSA Information Technology Incident Report Form **C.** Motor Vehicle Accident Form **D.** DPW Initial/Incident Report
VII. PROCEDURE	**Procedure A: Definition of an Employee Unusual Incident** Employee unusual incidents occur while a CFSA employee is on official duty executing the responsibilities and duties of the job, including agency offices, vehicles or in a field location. An employee unusual incident is defined as any significant occurrence or extraordinary event, different from the regular routine or established procedure. Unusual incidents include, but are not limited to: 1. Possession and/or use of alcohol and/or illegal/unauthorized substances by an employee while on official duty and executing the responsibilities and duties of his/her job, including agency offices or any field location 2. Death of an employee while on official duty or death of a visitor in the agency offices or any field location 3. Employee misconduct/fraud and abuse 4. Theft or destruction of property 5. Fire/bomb threats 6. Motor vehicle accidents 7. Serious injury of an employee requiring external medical care 8. Possession of conventional weapons (excluding possession by law enforcement personnel while executing their duties) 9. Unauthorized disclosure of any case related information 10. Any incident requiring the involvement of law enforcement authorities, fire or rescue units
	Procedure B: General Procedures for an Employee Unusual Incident Reporting The Employee Unusual Incident Report is part of the official record of the incident and ensures that the Agency is informed of any unusual incident that may require immediate attention. The Employee Unusual Incident Report Form (Attachment A) is used for reviewing the incident and may generate and investigation by the Office of Risk Management. Therefore, the Employee Unusual Incident Report Form (Attachment A) must detail all information related to the incident. The CFSA Office of Risk Management shall be the

point of contact and the coordination of all criminal investigations involving CFSA and law enforcement agencies and forward all necessary documents and information to the appropriate parties in conjunction with consultation when appropriate, with the CFSA Office of General Counsel.

1. Any employee who witnesses or has direct knowledge of an unusual incident shall immediately report it to their immediate supervisor both verbally and in writing, using the Employee Unusual Incident Report Form (Attachment A).

2. An employee shall complete the Employee Unusual Incident Report Form (Attachment A) and supplemental reports as directed by the supervisor or Risk Manager and submit the form to Office of Risk Management within twenty-four (24) hours of the incident or the next business day.

3. To ensure uniformity in reporting procedures and format, the Employee Unusual Incident Report Form (Attachment A) shall be the only reporting form used.

4. The Employee Unusual Incident Report Form (Attachment A) may be deemed sufficient as the final written report by the CFSA Office of Risk Management depending upon the nature of the unusual incident.

5. An employee shall participate in the investigation of the unusual incident at the direction of the Office of Risk Management.

6. The Employee Unusual Incident Report shall include a summary of actions taken by managerial officials regarding the unusual incident, and any corrective measures taken to prevent recurrences (immediate and long-term). The report shall be reviewed by the CFSA Office of Risk Management and disseminated to the appropriate parties and/or administrations for corrective action, if needed.

7. In the event that all facts are not included in the initial report, a follow-up report shall be submitted to the CFSA Office of Risk Management within 72 hours after the occurrence of the initial incident. However, if updated information is received after that timeframe, the Office of Risk Management shall incorporate it into the report. Administrators shall ensure that follow-up reports are submitted to relate subsequent information and actions.

8. When an employee unusual incident occurs between the hours of 4:45 p.m. and 8:15 a.m. on weekdays and any time on weekends or holidays, the employee shall report the incident to the security officer on duty at 202-442-6361. The employee shall also inform his or her supervisor of the incident upon returning to work and complete and submit an Employee Unusual Incident Form (Attachment A) to the office of Risk Management before the end of the employee's shift of the next business day.

    a. If the unusual incident constitutes an employee emergency, CFSA's security is directed to call the following individuals until a response is received:

i. Risk Management Specialist at 202-497-4282

ii. Human Resources (HR) Administrator at 202-497-9011

iii. Chief Administrative Officer at 202-403-9860

b. If the unusual incident involves an emergency impacting the building, CFSA security is directed to call the following individuals until a response is received:

i. Supervisory Inventory and Space Management Specialist at 202-409-0865

ii. Facilities Management Program Manager at 202-497-0140

iii. Chief Administrative Officer at 202-403-9860.

9. If the unusual incident involves the security of computer systems or information technology (i.e. the loss or damage of a device containing CFSA information), the employee shall complete a CFSA Information Technology Incident Report Form (Attachment B) as well as the Employee Unusual Incident Form (Attachment A), and follow the procedures outlined in the Information Technology Risk Assessment Policy.

a. Such incidents include, but are not limited to: lost, stolen, or damaged cell phones and/or smart phones, computers, lap tops, air cards, flash drives or any other device containing any CFSA information.

b. If the unusual incident report is regarding a lost, stolen, or damaged cell/smart phone, the employee shall also submit a copy of the Employee Unusual Incident Form (Attachment A) to the Facilities Management Administration (FMA) as well.

c. The Office of Risk Management shall confer with the Child Information System Administration (CISA) and other appropriate departments (e.g. FMA) to determine appropriate action regarding all lost, stolen or damaged devices containing CFSA information. *(See the Incident Security Response Policy and the Device and Media Controls Policy for more information)*

Note: An unusual incident report regarding security of computer systems or information technology shall be completed for all lost, stolen or damaged devices containing CFSA information; including devices owned by the District of Columbia and/or personal devices.

10. If the unusual incident concerns an employee's involvement in a vehicle accident in an agency vehicle or in the employee's personal vehicle while performing work-relating duties, the employee shall immediately complete a Motor Vehicle Accident Form (Attachment C), the DPW Initial/Incident Report (Attachment D), as well as the Employee Unusual Incident Form (Attachment A). Employees who are involved in a vehicular accident while driving, during the performance of their work duty, shall obtain a Chain of Custody Form located at Human Resources (HR) Administration or at the FMA in order to complete a drug/alcohol testing immediately, or within 24 hours of the incident, as directed by HR.

	Procedure C : Role of the CFSA Office of Risk Management The purpose of the CFSA Office of Risk Management is to help prevent, eliminate and/or reduce conditions and practices that present a potential risk of harm or loss. The CFSA Office of Risk Management shall: 1. Ensure copies of the Employee Unusual Incident Report Form (Attachment A) are forwarded to the appropriate department for follow-up within twenty-four (24) hours of receipt. In extreme cases requiring immediate corrective action, the appropriate department shall also be contacted verbally. 2. Ensure that the Agency Director or designee is contacted by telephone or written communication, immediately following an employee unusual incident requiring their attention. 3. Monitor the incident reporting process to determine compliance and implementation of the recommended corrective action. 4. Participate in investigations and provide assistance to management as necessary.
	Procedure D: Role of the Administrator, Manager, & Supervisor 1. Administrators, managers and supervisors are responsible for ensuring timely attention and resolution to employee unusual incidents. The Deputy Director shall be contacted by the administrator, manager or supervisor immediately upon knowledge of the following incidents: a. Death of an employee on official duty or of a visitor while on District Government premises; b. Employee misconduct, fraud and abuse; or c. Any incident requiring the involvement of law enforcement authorities, fire or rescue units. 2. Participate in investigations as necessary. 3. Ensure that the initial report is submitted to the Office of Risk Management within twenty-four (24) hours of the incident or the next business day. 4. In the event that all facts are not available and included in the initial report ensure that a follow-up report is submitted within seventy-two (72) hours and if additional information is obtained that it is immediately conveyed to the Office of Risk Management. 5. Report any injuries of an employee to Third Party Administrators (TPA) (the organization that processes workman's compensation) and provide the claim number to the Office of Risk Management. 6. Ensure the employee completes a Chain of Custody Form and drug/alcohol testing is done within 24 hours of the incident, if the incident concerns the possession and/or use of alcohol and/or illegal/unauthorized substances. 7. Ensure completion of the Motor Vehicle Accident Form (Attachment C), the DPW Initial/Incident Report (Attachment D), as well as the Employee

	Unusual Incident Form (Attachment A) if the employee is involved in a vehicle accident while performing work related duties. 8. Refer employees who are involved in a vehicular accident while driving, during the performance of their work duty, to HR or FMA to obtain a Chain of Custody Form and complete drug/alcohol testing immediately or within 24 hours of the incident, as directed by HR.
	Procedure E: Role of the Office of Human Resources The CFSA Office of Human Resources (HR) plays an integral role in the unusual incident reporting process. The CFSA Office of Human Resources shall: 1. Notify the appropriate administrator within twenty-four (24) hours of receipt of an employee unusual incident report if the report merits placing an employee on administrative leave pending the outcome of an investigation. 2. When applicable, notify the FMA and Child Information System Administration (CISA) to suspend service to employee's cell phone, Outlook and FACES. 3. Provide support/counseling through the Employee Assistance Program (EAP) for employees as needed. 4. Request appropriate documentation from the unusual incident investigation and maintain them in the personnel records. 5. Ensure that the supervisor has sent the employee to have a drug/alcohol test immediately, or within 24 hours of the incident, depending on the nature of the incident if the incident concerns a motor vehicle accident.
	Procedure F: Unusual Incident Reports Resulting in an external Investigation Employee unusual incidents may involve law enforcement officials and other external investigative components. 1. Employee unusual incidents that may require the involvement of law enforcement officials and other investigative components include but are not limited to the following situations: a. Serious or suspicious injuries to employees on official duty b. Possession, and/or distribution of alcohol and controlled substances by an employee on official duty c. Employee misconduct, fraud and abuse d. Theft of government property e. Illegal possession of weapons or any object used or attempted to be used to cause harm/injury f. Any incident requiring the involvement of law enforcement authorities, fire or rescue unit

	2. When such incidents occur, the CFSA Office of Risk Management, shall ensure the following procedures are implemented immediately: a. Notification of the Office of the General Counsel, if necessary. b. Notification of the Metropolitan Police Department (MPD), if necessary. c. In the event of a criminal investigation by the Protective Service Division (PSD), MPD or the Office of the Inspector General (OIG) the employee and/or victim should be removed from the immediate area to defuse the situation. Removal of an employee pending internal and criminal investigations may include such actions as reassignment or detail. Other instructions may come from PSD, MPD or OIG based on the individual circumstances of an investigation. d. Completion of an internal investigation by the Office of Risk Management, if necessary. *Note: CFSA staff shall not conduct an internal investigation prior to notifying the Office of the General Counsel and the Office of Risk Management. This includes taking statements or interviewing witnesses or victims. Such actions impede a criminal and internal investigation. Staff shall only gather the information that is required for the completion of the CFSA Employee Unusual Incident Report.* e. In the event there is suspicion of employee misconduct, fraud and abuse the Agency Director and OIG shall be notified immediately and no later than 24 hours after receipt of notification.

CHILD AND FAMILY SERVICES AGENCY
EMPLOYEE UNUSUAL INCIDENT (UI) REPORT

PART 1 - REPORTING SOURCE

1. **Name of Reporter:** _____

a. **Title/Position:** _____

b. **Administration:** _____

c. **Telephone Number** _____ d. **Date Reported:** _____ e. **Time Reported:** _____

2. **Has this incident been reported to Risk Management?** _____ **Yes** _____ **No** _____ **Don't Know**

If yes, please provide the following information to the best of your knowledge:

Person Reporting Incident to Risk Management: _____

a. **Title/Position:** _____

b. **Administration:** _____

c. **Telephone Number:** _____ d. **Date Reported:** _____ e. **Time Reported:** _____

PART 2 -TYPE OF INCIDENT

3. **Type of Incident:** _____

4. **Date of Incident:** _____ **Time of Incident:** _____

5. **Location/Place of Incident:** _____

6. **Individuals Involved and/or Witnesses to the Incident:** _____

_____

PART 3 - DETAILS OF INCIDENT

7. **(WHO? WHAT? WHEN? WHERE?)**

_____

_____

_____

_____

_____

_____

PART 4 - INTERVENING ACTION (S) TAKEN AND BY WHOM

_____

_____

_____

_____

_____

PART 5 - (FOR RISK MANAGEMENT USE ONLY)

_____

_____

_____

_____

Note: If necessary, attach separate sheet for additional information.

CFSA INFORMATION TECHNOLOGY INCIDENT REPORT FORM

DCERT Ref. #

Date/Time of Incident: **Date/Time of Report:**

Agency: **Address:**

User Info: First Name: _____ Last Name: _____ Phone: _____

Email: _____

User/Host location (if different from Agency address):

ISO/Tech Lead Info: First Name: _____ Last Name: _____ Phone: _____

Email: _____

Incident Type:				
	Misuse/Abuse of Computer Resources	☐	Unauthorized Access	☐
	Computer Virus/Worm/Trojan/ Detection	☐	Suspicious Activity	☐
	Distributed/Denial of Service	☐	Exploit	☐
	Network Availability	☐	Other:	☐

Initial Severity Assigned 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ HIPPA Related? YES ☐ NO ☐

Virus/Worm/Trojan Info: **Removed:** YES ☐ NO ☐

Antiviral Software: **Name:** **Version:** **Date:**

Host Info: Mainframe ☐ Workstation ☐ Server ☐ Network Device ☐ Other ☐ OS:

Source Address	**Port #**	**MAC Address**	**Destination Address**	**Port #**	**MAC Address**

Incident Details

Provide details of events leading up to incident if known, impact on users, details of theft or destruction, and how many users were affected

_____

_____

_____

_____

Action Taken

_____

_____

_____

_____

Name of Person Writing Report: _____

Signature: _____ **Date:** _____

DISTRICT OF COLUMBIA

MOTOR VEHICLE ACCIDENT

REPORT FORM

CLAIM CODE/PHONE #	AGENCY CONTACT INFORMATION	AGENCY

DATE OF ACCIDENT	TIME OF ACCIDENT AM: PM:	LOCATION ACCIDENT OCCURRED: ☐ NE ☐ NW ☐ SE ☐ SW _____ ft of _____ Street Street	STATE

TYPE OF ACCIDENT (check one)	TRAFFIC CONDITIONS (check one)	TRAFFIC CONTROLS (check one)	ROAD SURFACE (check one)	ROAD CONDITION (check one)
__ 00 Collision of vehicles __ 01 Collision with fixed object __ 02 On board school bus __ 03 Boarding/Alighting __ 04 Pedestrian __ 05 Fatality	__ 00 Unknown __ 01 Heavy __ 02 Medium __ 03 Light	__ 00 Unknown __ 01 Yield Sign __ 02 Signal __ 03 Officer __ 04 Turn Restricted __ 05 Flashing Light __ 06 Stop Sign __ 07 None __ 08 Other	__ 00 Unknowns __ 01 Concrete __ 02 Asphalt __ 03 Light __ 04 Gravel __ 05 Dirt __ 06 Other	__ 01 Unknown __ 02 Repairing __ 03 Dry __ 04 Wet __ 05 Ice

ROAD TYPE (check one)	LIGHT CONDITIONS (check one)	STREET LIGHTS (check one)	WEATHER (check ALL that apply) (check one)
__ 00 Straight __ 01 Curve __ 02 Level __ 03 Grade __ 04 Crest __ 05 Underpass __ 06 Ramp __ 07 Bridge __ 08 Divided	__ 00 Unknown __ 01 Dawn/Dusk __ 02 Dark __ 03 Daylight	__ 00 Unknown __ 01 Defective street light(s) __ 02 No street light(s) __ 03 Street light(s) on __ 04 Street light(s) off	__ 00 Unknown __ 01 Fog/Midst __ 02 Clear __ 03 Rain __ 04 Snow __ 05 Sleet

Total # of Vehicles Involved: _____

District Driver & Vehicle Information

District Vehicle No. _____ # of Passengers in District Vehicle: _____ # of Passengers Injured in District Vehicle: _____

District Operator (Last Name, First Name, M.I.) Age Sex Full or Part-time (FT or PT) Driver Injured: Yes No

_____ _____ _____ _____

Drivers License # _____ License State: _____ Home Phone #: ( ) _____- _____ Cell Phone #: ( ) _____- _____

Vehicle Model/Year Make Body Style Tag #/State/Year Vehicle Color Vehicle Damaged: Yes or No

_____ _____ _____ _____ _____

Speed at time of Impact: _____ mph Skid Mark Details: _____

Vehicle Driven Away: Yes or No Vehicle left at scene: Yes or No If towed, to where: _____

VEHICLE TYPE
(check one)
__ 00 Passenger Auto
__ 01 Bus
__ 02 Truck
__ 03 Trailer
__ 04 Other
__ 05 Heavy Equipment

DRIVER CONDITION
(check ALL that apply)
__ 00 Fatigued
__ 01 Ill
__ 02 Physical defect
__ 03 Asleep
__ 04 Normal
__ 05 Unknown
__ 06 Ability Impaired
__ 07 Ability not impaired

PRIMARY CAUSE OF ACCIDENT:
Insert ONE code from below for **DISTRICT** vehicle here: ☐ Insert ONE code from below for **CLAIMANT** vehicle here: ☐

__ 00 Speed
__ 01 Defective brakes
__ 02 Signal
__ 03 Auto right of way
__ 04 Pedestrian right of way
__ 05 Improper Turn
__ 06 Yield Sign
__ 07 Stop/Go light
__ 08 Flashing light
__ 09 Directional light
__ 10 Stop Sign
__ 11 Alcohol influence
__ 12 Improper passing
__ 13 One way street-wrong way
__ 14 Wrong side of street
__ 15 Improper starting
__ 16 Other Defects
__ 17 Pedestrian Violation
__ 18 Driver inattention
__ 19 Changing lanes no caution
__ 20 Failure to set parking brake
__ 21 Opened door in traffic
__ 22 Drug influence
__ 23 Improper Backing
__ 22 Defective light(s)
__ 23 Pedestrian drunk
__ 24 Road defects
__ 25 Road defects
__ 26 Driver vision obstructed
__ 27 Other: _____
_____
_____

DISTRICT OF COLUMBIA

MOTOR VEHICLE ACCIDENT

REPORT FORM

Claimant Information

Claimant (Last Name, First Name, M.I.) _____ Age _____ Sex _____ Estimated Damage $_____

Home Address _____ Business Address _____

Drivers License #/State _____ Home Phone #: ( ) ____- _____ Alternate Phone #: ( ) ____- _____

Vehicle Damaged: Yes or No Speed at time of Impact: _____ mph Skid Mark Details: _____
Was vehicle driven away? Yes or No Was vehicle left at the scene? Yes or No If towed, to where: _____
Tow Co. Info. _____

INJURY CODE (check ALL that apply)
__ 00 Fatal __ 01 Disabling __ 02 Non-disabling __ 03 None
__ 04 Unknown __05 No visible injury __ 06 complaint of pain/no visual injury

CLAIMANT CONDITION (check one)
__ 00 Fatigued __ 01 Ill __ 02 Physical defect
__ 03 Asleep __ 04 Normal __ 05 Unknown
__ 06 Ability Impaired __ 07 Ability not impaired

TYPE OF VEHICLE (check one):
__ 00 Passenger Auto __ 01 Bus __ 02 Truck __ 03 Trailer __ 04 Unknown __ 05 Taxi __ 06 Motorcycle __ 07 Bicycle
__ 08 Fire engine __ 09 Ambulance __ 10 Fixed Object __ 11 Vendor Cart __ 12 Other: _____

# of Passengers in Claimant Vehicle: _____ # of Passengers Injured in Claimant Vehicle: _____
Do you have Collision Insurance? ____Yes ___No Amount of Deductible $_____

Additional Claimant Information

Claimant (Last Name, First Name, M.I.) _____ Age _____ Sex _____ Estimated Damage $ _____

Home Address _____ Business Address _____

Drivers License #/State _____ Home Phone #: ( ) ____- _____ Alternate Phone #: ( ) ____- _____

Vehicle Model/Year: _____ Tag #/State/Year: _____

Make: _____ Vehicle Color: _____

Body Style: _____

Vehicle Damaged: Yes or No Speed at time of Impact: _____ mph Skid Mark Details: _____
Was vehicle driven away? Yes or No Was vehicle left at the scene? Yes or No If towed, to where: _____
Tow Co. Info. _____

INJURY CODE (check ALL that apply)
__ 00 Fatal __ 01 Disabling __ 02 Non-disabling __ 03 None
__ 04 Unknown __05 No visible injury __ 06 complaint of pain/no visual injury

CLAIMANT CONDITION (check one)
__ 00 Fatigued __ 01 Ill __ 02 Physical defect
__ 03 Asleep __ 04 Normal __ 05 Unknown
__ 06 Ability Impaired __ 07 Ability not impaired

TYPE OF VEHICLE (check one):
__ 00 Passenger Auto __ 01 Bus __ 02 Truck __ 03 Trailer __ 04 Unknown __ 05 Taxi __ 06 Motorcycle __ 07 Bicycle
__ 08 Fire engine __ 09 Ambulance __ 10 Fixed Object __ 11 Vendor Cart __ 12 Other: _____

# of Passengers in Claimant Vehicle: _____ # of Passengers Injured in Claimant Vehicle: _____
Do you have Collision Insurance? ____Yes ___No Amount of Deductible $_____

DISTRICT OF COLUMBIA

MOTOR VEHICLE ACCIDENT

REPORT FORM

Pedestrian/Vehicle Actions:

____ Unknown_ ___ With signal in crosswalk

____ Against signal n crosswalk ___ In crosswalk-no signal

____ From between parked cars ___ Backing up

____ Turning right ____ Turning left

_____Parked ____ Entering/leaving parking

____ Making U-Turn ____ Run off Road

____ Slowing/stopping ____ Overtaking

____ Changing lanes ____ Going straight

____ Stopped ____ Avoiding

_____ Other: _____

Witnesses Information:

Name Address Phone Number

1. _____

2. _____

3. _____

LOCATION OF ACCIDENT:

____ At intersection

___ Not at intersection

___ At crosswalk

___ Not at crosswalk

___ Other:_____

Injured Person(s) Information:

Name/Address Phone Number Injuries/Which Vehicle

1. _____

2. _____

3. _____

INDICATE AREA OF DAMAGE TO VEHICLES BELOW:

District Vehicle

Front Rear

Claimant Vehicle

Front Rear

Description of Accident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Example:

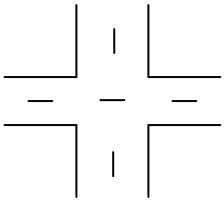

Diagram N

W E

S

Supervisor at Scene: _____ Complaint No.: _____

Investigating Police Officer: _____ Badge No.: _____ District/Precinct: _____

Phone #: _____

Signature of District Driver: _____ Date: _____

FAX COMPLETED FORM TO: (202) 727-0249

GOVERNMENT OF THE DISTRICT OF COLUMBIA
INITIAL/INCIDENT REPORT

NOTE: <u>USE THIS FORM TO INITIALLY REPORT INCIDENTS.</u> To be completed by the investigating supervisor. This report must be faxed to the Department Safety Manager and your Administrator/Division Chief ASAP, but **no later than the end of your shift**. You must follow all procedures outlined in the latest copy of the Department's Accident Notification Procedures. **Contact Safety @ Nextel Call Number 2413. For questions concerning CDL Drug/Alcohol, contact DPW Drug and Alcohol Coordinator @ Nextel Call Number 2696!!**

ADMINISTRATION/DIVISION: _____
DATE/TIME OF INCIDENT: _____
ADDRESS OF INCIDENT: _____

EMPLOYEE(S) INVOLVED

DRIVER/OPERATOR: _____
NAME: _____
NAME: _____

DPW VEHICLE/EQUIPMENT INVOLVED

VEHICLE/EQUIPMENT/MAKE/MODEL: _____
VEHICLE/EQUIPMENT TAG NUMBER:_____
DESCRIBE DAMAGE: _____

OTHER OPERATOR/VEHICLE INVOLVED

NAME/ADDRESS: _____
INSURANCE COMPANY NAME/ADDRESS: _____
WITNESS NAME/ADDRESS: _____
WITNESS NAME/ADDRESS: _____
TYPE VEHICLE/TAG NUMBER: _____
DESCRIBE DAMAGE: _____

PLEASE PROVIDE A BRIEF DESCRIPTION OF WHAT HAPPENED

SUPERVISOR'S NAME/PHONE: _____
POLICE OFFICER'S BADGE #/REPORT #: _____
DATE FAXED TO SAFETY: (202-671-0613): _____

PLEASE DISTRIBUTE TO OTHERS WITHIN YOUR ADMINISTRATION ACCORDINGLY

DPW Initial Incident Report Form – A product of DPW RACC: October 2002