City Of Little Rock

Vehicle Accident-Incident Report Form

Employee: _____ **Department Name:** _____

Vehicle #: _____ **Division Name:** _____

Division Code #: _____ **Date & Time of Accident-Incident:** _____

Location: _____

Description of Accident or Incident

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Employee Signature: _____ **Supervisor Signature:** _____

Date Form Completed: _____

*This form should be completed and submitted to Fleet Services along with a Supervisor's Investigation Report Form within three (3) days of the incident.