



BULLOCH COUNTY BOARD OF COMMISSIONERS INCIDENT REPORT FORM

Date of Accident / Incident: _____ Time: _____ AM PM
Name of employee(s) involved: _____ Department: _____
Where did accident / damage occur: (Address/Location): _____
Details (What happened?) _____

Witness Name/Phone (Use additional sheet if needed): _____
Reported to: BCSO SPD GSP OTHER: _____ Report / Accident # _____

Damage to Bulloch County property: (If none, leave blank)

What property was damaged? (If a vehicle, include last four digits of VIN) _____

Describe damage: _____
Estimate cost, if known: _____

Damage to property owned by another person/organization: (If none, leave blank)

What property was damaged? _____
Describe damage: _____
Property owner's name: _____
Property owner's address: _____
Property owner's phone #: _____

Injury/Illness to non-employees: (For injured employees, complete Injury Report form)

Name: _____
Address: _____
Phone: _____ Email: _____
Injured Person is: Participant Volunteer Member of Public Other
Details of Injury _____
Action: No Treatment First Aid Ambulance Called Taken to Hospital Notified Parent/Gaurdian

Name of Person Completing this Form: _____

Signature: _____ Date: _____