

# City Of Little Rock

## Vehicle Incident Report Form

**Employee:** \_\_\_\_\_ **Department Name:** \_\_\_\_\_

**Vehicle #:** \_\_\_\_\_ **Division Name:** \_\_\_\_\_

**Division Code #:** \_\_\_\_\_ **Date & Time of Incident:** \_\_\_\_\_

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

### Description of incident

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**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.