



**Department of Human Services  
Office of Facilities and Support Services, Transportation Services  
Section Vehicle Operator Initial Accident and Incident Reporting Form**

This form is to be completed by local vehicle operators to report accidents and/or incidents involving consumers of the Coordinated Transportation or those transported in a Department of Human Services' (DHS)/Department of Behavioral Health and Developmental Disabilities' (DBHDD) vehicle, and accidents involving administrative vehicles. This may include vehicle accidents, consumer injuries, behavior incidents or any incident the vehicle operator feels should be reported. Complete this form with as much detail as possible and send/email to the appropriate DHS Regional Transportation Office within **24 hours** of the accident/incident. Requests for additional information may follow.

**Vehicle Accident**       **Incident**       **Illness**       **Observation**       **Other\***

**\*If Other, please explain:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Vehicle #:** \_\_\_\_\_ **Tag #:** \_\_\_\_\_ **Vehicle Operator:** \_\_\_\_\_

**Vehicle Operator Type:**  **DHS/DBHDD**     **Direct Contractor**     **Subcontractor**

**Police Notified:**  **Yes**     **No\*\***    **Report Filed:**     **Yes**     **No\*\***

**\*\*If No, please explain:** \_\_\_\_\_

**Description (Be specific, include all consumers involved and add additional pages if necessary):**

**Any witnesses to the accident/incident?**  **Yes**     **No**    **# of consumers on board:** \_\_\_\_\_

**Were consumers Injured?**  **Yes**     **No**

**Consumer Name(s)(no initials)** \_\_\_\_\_  
(attach additional sheets if necessary)

**Medical treatment provided?**  **Yes**     **No**    **Medical treatment refused?**  **Yes**     **No**

**Location of medical treatment:** \_\_\_\_\_

**Human Service Provider (HSP) notified:**  **Yes**     **No**    **HSP phone:** \_\_\_\_\_

**HSP name** (attach a list for multiple HSPs): \_\_\_\_\_

**Parent or guardian of consumer notified?**  **Yes**     **No**    **Person notified:** \_\_\_\_\_

**Name of person issuing this report (print name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**On behalf of:** \_\_\_\_\_

**DHS Staff Use Only**

**Last DHS inspection of vehicle operator (date):** \_\_\_\_\_ **Corrective Actions?**  **Yes**     **No**

**Corrective actions followed up on by TSS?**  **Yes**     **No**    **Completed?**  **Yes**     **No**

**DHS Staff involved in inspections:** \_\_\_\_\_

**DHS Staff reviewing and submitting report:** \_\_\_\_\_

**Date report was received by RTO:** \_\_\_\_\_ **Date RTO sent to TSS Atlanta:** \_\_\_\_\_