

# River Valley Child Development Services

## Safe Driver Self-Report Form

**This form must be completed within 8 hours of occurrence and sent to Human Resources within 24 business hours.**

Did the moving violation/accident occur during the performance of your job? If yes, complete this form in its entirety, according to the section.

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### Section 1 - Moving Violation

Employee Name: \_\_\_\_\_

Program: \_\_\_\_\_ Regular work hours: \_\_\_\_\_

When did the moving violation occur? Date: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm

State where moving violation occurred: \_\_\_\_\_

Type of Violation: \_\_\_\_\_

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Employee \_\_\_\_\_ Date \_\_\_\_\_

Safety Coordinator \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Please attach copy of citation/documentation upon submission\*\*\*

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### Section 2- Auto Accident

Employee Name: \_\_\_\_\_

Program: \_\_\_\_\_ Regular work hours: \_\_\_\_\_

Was there an injury? \_\_\_\_\_

Body part(s) injured (be specific): \_\_\_\_\_

Type of injury (cut, bruise, break, sprain, strain): \_\_\_\_\_

Do you anticipate being treated by doctor?  Yes  No

When did the incident/accident occur? Date: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm

Where did the incident/accident occur? (Be very specific) \_\_\_\_\_

(Incident Cont'd.)

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How did the incident/accident occur? (Be specific. Explain what you were doing and people, equipment, and objects involved.)

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Name of individual(s) involved: \_\_\_\_\_

Address(es): \_\_\_\_\_

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Telephone Numbers: \_\_\_\_\_

List any witnesses to this incident/accident and how may they be contacted?

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\_\_\_\_\_  
Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Safety Coordinator

\_\_\_\_\_  
Date

\*\*\*Please include copy of police report, if possible\*\*\*