

# University of California, Davis Report of Vehicle Accident Form



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SANTA BARBARA • SANTA CRUZ

## RISK MANAGEMENT SERVICES

Insurance Information:

(The Regents of the University of California are Self-Insured),

Direct inquires to:  
UC Davis Risk Management Services

202 Cousteau Place, Suite 115  
Davis, California 95618  
Phone No: (530) 757-8379/8391  
Fax No: (530) 757-8385

## Instructions:

Use the Report of Vehicle Accident to report an accident involving a UC Davis vehicle. Please ensure forms are as complete as possible. Please use Blue or Black ink. Submit completed forms to UC Davis Risk Management Services.

## Date/Time/Location of Accident:

Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_  
Please Include: Address/City/County/Intersection/Etc.  
 Incident Only (Under \$500 Deductible)

## University Vehicle:

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ License #: \_\_\_\_\_ Fleet ID #: \_\_\_\_\_

Vehicle Ownership:  Fleet Services  Dept. Owned  Other: \_\_\_\_\_

Name of Department: \_\_\_\_\_ Division: \_\_\_\_\_ Ph. # \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Ph.# \_\_\_\_\_ Email: \_\_\_\_\_

Name of Driver: \_\_\_\_\_ Ph. # \_\_\_\_\_ Wk # \_\_\_\_\_ DOB: \_\_\_\_\_

Driver's Address: \_\_\_\_\_ Driver's Lic. \_\_\_\_\_  Male  Female

Relation to UC:  Faculty  Staff  Student Was Vehicle Used with Owners Permission:  Yes  No

Purpose of vehicle at the time of accident: \_\_\_\_\_

Specify type of damage to vehicle (Where & Type): \_\_\_\_\_

Reported to Police (if Yes):  Name of Agency: \_\_\_\_\_ Name of Officer: \_\_\_\_\_

Badge No.: \_\_\_\_\_ Location: \_\_\_\_\_ Case Report # \_\_\_\_\_

Was There?  Fuel Spilled  Vehicles' Towed

## Damage to Property of Others:

Driver (If not Owner): \_\_\_\_\_ Driver's Lic. \_\_\_\_\_  Male  Female DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Ph. # \_\_\_\_\_ Wk. # \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Owner: \_\_\_\_\_ Ph. # \_\_\_\_\_ Wk. # \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Vehicle: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Vehicle License #: \_\_\_\_\_

Other Property/Vehicle Damage: \_\_\_\_\_

## Persons Injured: (Write NONE if no injuries)

Name	Address	Phone #	Age	UC	Other	Type of Injuries
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	

**Transportation of Injured Parties:**

Name	Medical Provider	Employer Name/Phone #	Medical Facility Taken	Form of Transportation
				<input type="checkbox"/> Ambulance <input type="checkbox"/> Self
				<input type="checkbox"/> Ambulance <input type="checkbox"/> Self
				<input type="checkbox"/> Ambulance <input type="checkbox"/> Self

**Witnesses:**

**Occupants of UC car**

Name	Address	Phone #	Wk Ph. #

**Occupants of Other Car**

Name	Address	Phone #	Wk Ph. #

**Other Witnesses of Persons Present**

Name	Address	Phone #	Wk Ph. #	Witness Location

**Accident Description:**

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**Risk Management & Fleet Use Only:**

Incident Report #: \_\_\_\_\_ Account Name: \_\_\_\_\_ Acc.# to be Charged: \_\_\_\_\_  
 Estimate of Accident: \_\_\_\_\_