

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:

Incident/Claim #:

Use the Report of Vehicle Accident Form to report an accident involving a UC Davis vehicle. Please direct completed forms to UC Davis Risk Management Services for departmentally owned vehicles or Fleet Services for fleet vehicles within 24 hours of the accident. Please submit completed forms online.

Risk Management Services Only:

Juris Account #: _____ Juris Unit #: _____ Juris Sub-Unit #1: _____

Juris Sub-Unit #2: _____ Juris Sub-Unit #3: _____ Cause Code: _____

What is your email address to receive a copy: _____

Is there anyone else that should receive a copy? (Email Address): _____

Date/Time/Location of Accident:

Date: _____ Time: _____ AM PM Location: _____

Please Include: Address/City/County/Intersection/Etc.

Incident Only (Under Deductible/Uninsured)

University Vehicle:

Year: _____ Make: _____ Model: _____ License #: _____ Fleet ID #: _____

Vehicle Ownership: Fleet Services Dept. Owned Other: _____

Name of Department: _____ Division: _____

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:**Reimbursement Information:**

Account Name: _____ Acct.# to be reimbursed: _____

Signature:

Signature of Driver: _____ Date: _____