

University of California, Davis Report of Vehicle Accident Form



BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

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 to report an accident involving a UC Davis vehicle. Please direct completed forms to UC Davis Risk Management Services. Forms can be submitted online or via fax.

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: _____ Div. # _____
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: _____ Acc.# to be reimbursed: _____

Estimate of Accident: _____

Signature

Signature of Driver: _____ Date: _____