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University of California, Davis
Report of Vehicle Accident Form

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SANTA BARBARA • SANTA CRUZ

RISK MANAGEMENT SERVICES
One Shields Ave.
Davis, California 95616
Phone No: (530) 752-3003/2629
Fax No: (530) 752-3439

Insurance Information: (The Regents of the University of California are Self-Insured),
Direct inquires to:
UC Davis Risk Management Services

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
				☐	☐	
				☐	☐	
				☐	☐	

Transportation of Injured Parties:

Name	Medical Provider	Employer Name/Phone #	Medical Facility Taken	Form of Transportation
				☐ Ambulance ☐ Self
				☐ Ambulance ☐ Self
				☐ Ambulance ☐ 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: _____