

# University of California, Davis

## Report of Vehicle Accident Form

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### RISK MANAGEMENT SERVICES

Insurance Information:

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

Direct inquires to:  
UC Davis Risk Management Services



One Shields Ave.  
Davis, California 95616  
Email: rms@ucdavis.edu  
Fax No: (530) 752-3439

### 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: \_\_\_\_\_