



MOTOR VEHICLE ACCIDENT REPORT

Liability Only Physical Damage Non-Owned

System Risk Management
The Texas A&M University System
301 Tarrow St. 5th Floor
Campus Mail 1262
College Station, Texas 77840
Phone Number: (979) 458-6330
Fax Number: (979) 458-6247

DATE	Date Of Accident _____		Day of Week _____		AM <input type="checkbox"/>			
					PM <input type="checkbox"/>			
LOCATION OF ACCIDENT	Highway/Street/Road on which Accident Occurred _____				Under Construction Yes <input type="checkbox"/> No <input type="checkbox"/>			
	County _____	City or Town _____		State _____				
	<input type="checkbox"/> AT ITS INTERSECTION WITH _____ <input type="checkbox"/> IF NOT INTERSECTION _____ FEET <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> OF _____ <div style="text-align: center; font-size: small;">N S E W</div> <small>Show intersecting street or highway, house no., bridge, RR crossing, alley, driveway, culvert, milepost, underpass, or other landmark.</small>							
SYSTEM VEHICLE	Year _____	Make/ Model _____	Plate No. _____		Seat Belts In Use Yes <input type="checkbox"/> No <input type="checkbox"/>			
	V.I.N.: _____	Unit Number _____						
	System Member _____		Department _____					
	Driver _____		System Employee? (Yes or No) _____					
	Towing Trailer Yes <input type="checkbox"/> No <input type="checkbox"/>		Residence Phone _____	Business Phone _____				
DRIVER INFORMATION	Description of Trailer _____		Owner _____					
	Driver's Occupation _____	Driver's License No. _____	Driving Experience (yrs) _____	Approximate Damage _____				
	Date of Birth _____	Speed You Were traveling _____ mph	Type of License <input type="checkbox"/> Class A <input type="checkbox"/> Class B <input type="checkbox"/> Class C <input type="checkbox"/> Com. Op					
	Year Model _____		Type & Make Vehicle _____	Vehicle License No. _____				
	Driver _____		Address _____ <small>(Include City and State)</small>		Phone _____			
OTHER VEHICLE	Owner _____		Address _____ <small>(Include City and State)</small>		Phone _____			
	Driver's Date of Birth _____		Driver's License Number _____					
	Insurance Company _____		Policy Number _____					
	Agent _____		Address _____		Phone _____			
	PROPERTY DAMAGE	Describe Property _____						
Owner _____		Address _____		Phone _____				
Describe Damage _____			Estimate Damage _____					
INJURED	Name & Address _____		Phone _____	PED <input type="checkbox"/>	SYS Veh <input type="checkbox"/>	Other Veh <input type="checkbox"/>	Age _____	EXTENT OF INJURY _____
	Name & Address _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Name & Address _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Name & Address _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Name & Address _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

WITNESSES OR PASSENGERS	Name & Address _____	Phone _____	SYS Veh	Other Veh	OTHER (SPECIFY) _____
	Name & Address _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Name & Address _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Name & Address _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Name & Address _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

POLICE REPORT CITATION ISSUED	Police Report	
	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state which agency _____	
	Case No. _____	Phone Number _____
	Officer Name _____	Charge(s) _____

PURPOSE OF TRIP	Was System Vehicle in Emergency Response? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Brief Explanation of <u>Trip Purpose</u> : _____

NARRATIVE OF ACCIDENT	Briefly describe how accident occurred

DIAGRAM
Indicate North

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ACCIDENT TYPE
Check Applicable Box <input type="checkbox"/> Head-on Collision <input type="checkbox"/> Collision with Fixed Object <input type="checkbox"/> Rear-End Collision <input type="checkbox"/> Ran Red Light/Stop Sign <input type="checkbox"/> Hit and Run Collision <input type="checkbox"/> Collision with Pedestrian <input type="checkbox"/> Collision with Bicyclist or Motorcycle <input type="checkbox"/> Backed without Safety <input type="checkbox"/> Vehicle Roll Over/Jackknife <input type="checkbox"/> Changing Lanes Collision <input type="checkbox"/> Passing and/or Turning Collision <input type="checkbox"/> Collision between two State Vehicles/Equipment <input type="checkbox"/> Collision with Parked Vehicle <input type="checkbox"/> Object Thrown from/by State Vehicle <input type="checkbox"/> Hit in Side by Other Vehicle <input type="checkbox"/> Struck by Falling or Flying Objects <input type="checkbox"/> Collision with Animal (wild or domestic) <input type="checkbox"/> Fire <input type="checkbox"/> Theft <input type="checkbox"/> Vandalism <input type="checkbox"/> Windshield <input type="checkbox"/> Failed to Yield Right of Way <input type="checkbox"/> Other

Supervisor's Name _____ Title _____ Phone # _____

Driver's Signature _____ Date _____

PLEASE NOTE: You must notify Risk Management within **24 hours** of an automobile accident. In addition, you must furnish a completed MVAR within **48 hours** to Risk Management either by fax (979)458-6247 or email to RMS-insurance@tamus.edu.

For further information or support, please contact your Vehicle Coordinator or System Risk Management. You can also visit System Risk Management's web site <http://www.tamus.edu/business/risk-management/>