



MOTOR VEHICLE ACCIDENT REPORT

FLEET EXECUTIVE HIRED & NON OWNED

System Risk Management
The Texas A&M University System
200 Technology Way, Suite 1120
Campus Mail 1262
College Station, Texas 77845
Phone Number: (979) 458-6330
Fax Number: (979) 458-6247

DATE	Date Of Accident _____	Day of Week _____	Hour _____	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 _____	
		<small>Show intersecting street or highway, house no., bridge, RR crossing, alley, driveway, culvert, milepost, underpass, or other landmark.</small>

SYSTEM VEHICLE DRIVER INFORMATION	Year Model _____ Type & Make Vehicle _____ Vehicle License No. _____
	V.I.N.: _____ Unit Number _____ Seat Belts In Use Yes <input type="checkbox"/> No <input type="checkbox"/>
	System Member _____ Part Number _____ Department _____
	Driver _____ Address _____
	Towing Trailer Yes <input type="checkbox"/> No <input type="checkbox"/> Residence Phone _____ Business Phone _____
	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	

OTHER VEHICLE DRIVER INFORMATION	Year Model _____ Type & Make Vehicle _____ Vehicle License No. _____
	Driver _____ Address _____ Phone _____
	Owner _____ Address _____ 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	SYS Veh	Other Veh	Age	EXTENT OF INJURY
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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

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

PURPOSE OF TRIP	Brief Explanation of Trip Purpose _____
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NARRATIVE OF ACCIDENT	Briefly describe how accident occurred _____
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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 <i>(Briefly describe)</i>

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 or email to RMS-insurance@tamu.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/offices/safety/risktransfer/index.html>