



MOTOR VEHICLE ACCIDENT REPORT

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

Liability Only Physical Damage Non-Owned

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="display:flex; justify-content:space-around; font-size:small;"> NSEW </div> <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 _____	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 _____			
	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 _____ <small>(Include City and State)</small>		Phone _____			
	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	C O M P L E T E	ACCIDENT TYPE
Indicate North _____		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/>