



STATE OF CALIFORNIA - DGS ORIM

# VEHICLE ACCIDENT REPORT

STD. 270 (REV. 2/2002c)

**THIS REPORT MUST BE MAILED WITHIN 48 HOURS AFTER ACCIDENT  
(ACCIDENTS INVOLVING INJURY SHOULD FIRST BE CALLED OR FAXED  
TO ORIM AT (916) 376-5302 - CALNET 480-5302 - FAX (916) 376-5277.)**

**\* CONFIDENTIAL INFORMATION \***

**DO NOT RELEASE TO OTHER PARTIES WITHOUT CONSENT OF THE  
OFFICE OF RISK AND INSURANCE MANAGEMENT**

**DISTRIBUTION: OFFICE OF RISK AND  
INSURANCE MANAGEMENT  
ORIGINAL - 707 THIRD STREET, FIRST FLOOR  
WEST SACRAMENTO, CA 95605**

COPY - STATE GARAGE (DGS pool vehicle only)

COPY - DEPT. FILES (Dept. owned vehicles only)

COPY - STATE DRIVER

(Dept. owned vehicles only)

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ACCIDENT PREVIOUSLY REPORTED TO ORIM? (If Yes, give date)

YES  NO

STATE DRIVER	NAME		AGE	EMPLOYING DEPARTMENT	AGENCY BILLING CODE
	DRIVER'S LICENSE NO.	ACCIDENT DATE	TIME	OFFICE ADDRESS	AGENCY DOCUMENT NO. (Optional)
	WAS VEHICLE BEING USED ON OFFICIAL STATE BUSINESS? (If NO, attach explanation)		<input type="checkbox"/> YES <input type="checkbox"/> NO		
	DATE DRIVER LAST COMPLETED STATE DEFENSIVE DRIVER TRAINING	Month/Year	<input type="checkbox"/> NOT TAKEN	JOB TITLE	BUSINESS TELEPHONE

STATE VEHICLE	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL	VEHICLE OWNER	DEPT. VEHICLE NO. (Optional)
	DESCRIBE DAMAGES TO STATE VEHICLE		<input type="checkbox"/> DEPARTMENT OWNED <input type="checkbox"/> DGS POOL <input type="checkbox"/> RENTAL <input type="checkbox"/> EMPLOYEE OWNED IF DEPARTMENT OWNED OR RENTAL, ENTER OWNER'S NAME	
		ESTIMATED REPAIR COST		

ACCIDENT DETAILS (See Reverse for Diagram and Description)	ACCIDENT LOCATION (Address/Area)		ROAD CONDITIONS	
	(City/State)		WEATHER CONDITIONS	
	(County)		TRAFFIC CONDITIONS	
	POLICE REPORT MADE		NAME AND ADDRESS OF INVESTIGATING AGENCY	
	<input type="checkbox"/> YES <input type="checkbox"/> NO AGENCY <input type="checkbox"/> CHP <input type="checkbox"/> OTHER			
		HOW FAST WERE YOU DRIVING?	EST. SPEED OF OTHER CAR	

OTHER VEHICLE	DRIVER'S NAME	AGE / DOB	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL	NO. OF PASSENGERS
	DRIVER'S LICENSE NO.	HOME TELEPHONE	WORK TELEPHONE	REGISTERED OWNER	
	DRIVER'S ADDRESS (Street, City, State, Zip Code)			OWNER'S ADDRESS	HOME TELEPHONE
					WORK TELEPHONE
BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY				NAME AND ADDRESS OF OTHER PARTY'S INSURANCE	

INJURED	NAME	AGE	ADDRESS	HOSPITAL
	NAME	AGE	ADDRESS	HOSPITAL

WITNESS	NAME	TELEPHONE	ADDRESS
	NAME	TELEPHONE	ADDRESS

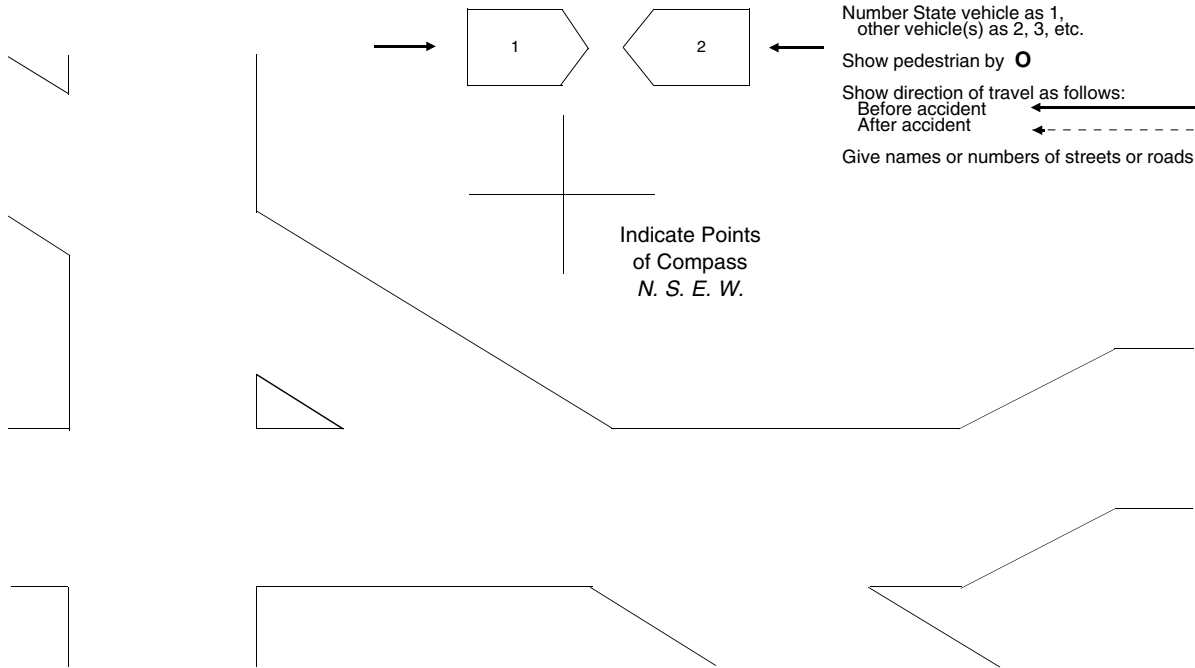
VEHICLE PASSENGERS STATE OTHER	NAME	ADDRESS
	NAME	ADDRESS
	NAME	ADDRESS
	NAME	ADDRESS

(CONTINUE ON REVERSE)

ACCIDENT DETAILS - DESCRIPTION

FULLY STATE HOW ACCIDENT OCCURRED (Give details, attach additional sheets if necessary)

ACCIDENT DETAILS - DIAGRAM



ADDITIONAL VEHICLE/PASSENGER(S)	DRIVER'S NAME		AGE/DOB	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL
	DRIVER'S LICENSE NO.	HOME TELEPHONE	WORK TELEPHONE	REGISTERED OWNER	
	ADDRESS (Street, City, State, Zip Code)			ADDRESS (Street, City, State, Zip Code)	HOME TELEPHONE
	BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY			WORK TELEPHONE	
PASSENGER	NAME AND ADDRESS OF OTHER PARTY'S INSURANCE CARRIER				
	NAME	AGE	ADDRESS	HOSPITAL	
	NAME	AGE	ADDRESS	HOSPITAL	
	NAME	ADDRESS			
	NAME	ADDRESS			

<i>The answers in this report contain a true and full account of the accident, and the vehicle was being operated on official business of the state at the time of the accident. (The reviewing officer is to explain any exception.) Attach extra pages as necessary.</i>		Type Name and Title of Reviewing Officer
Employee Signature and Date	Reviewing Officer Signature (Supervisor or Safety Coordinator)	Telephone Number of Reviewing Officer