CONFIDENTIAL: CLAIM INVESTIGATIVE MATERIALS

COMMONWEALTH OF VIRGINIA

Automobile Incident Report

Vehicle Pool Number

ODU Driver: Complete this form within 24 hours of the accident and email it to Risk Management at risk@odu.edu or send by fax: 757-683-6025.

If available, include a copy of the police report

Do not discuss accident with anyone except Commonwealth of Virginia representative and police

Section	Fields
Your Agency	Name of agency and institution / division; State vehicle's license plate number; Agency address: Street / P.O. Box, City, State, Zip code; Phone number
Time and Place of Accident	Date of accident; Hour A.M. / P.M.; Location: Street or highway; City /County; State

BY THE TERMS OF THE AGENCY'S COVERAGE THE COMMONWEALTH MUST BE GIVEN A REASONABLE OPPORTUNITY TO EXAMINE YOUR AUTO BEFORE REPAIRS ARE MADE.

Section	Fields
Your Auto	Make of auto; Year; Body type; Vehicle Identification Number; Police called? Y N; Name of police department
	Name of owner or leasing company; Address: Street, City, State, Zip Code
	Name of driver; Address: Street, City, State, Zip Code
	Driver's date of birth; Driver's license number; Was license in effect at time of accident?
	Purpose of trip; Who gave permission?; Where were you going when the accident happened?; Where were you coming from when the accident happened?
	Where is the vehicle now?; Estimated cost of repairs
Other Auto Involved	Make of other auto; Year; Body type; Estimated cost of repairs
	Describe damage to other auto
	Name of other driver; Address: Street, City, State, Zip Code
	Name of other auto's owner; Address: Street, City, State, Zip Code
	Is other auto insured?; Name of other auto's insurance company & Policy Number or Policyholder's Name
Passengers	Names of passengers in your auto; Addresses: Street, City, State, Zip Code
	Names of passengers in other auto; Addresses: Street, City, State, Zip Code
Injuries (No matter how minor)	Names of persons injured; Addresses; Injuries; Age
	In which auto were the injured riding?
	Name of doctor / hospital; Addresses: Street, City, State, Zip Code

NEITHER SUBMITTED NOR ACCEPTED AS NOTICE IN SATISFACTION OF ANY FILING REQUIREMENTS

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Property Damage Other than Auto	Name of owner	Address Street	City	State	Zip Code
	Kind of property				
	Estimated cost of repair	Where may property be seen?			

Witnesses	Names / phone numbers	Addresses Street	City	State	Zip Code

Description of Accident

On what street were you driving?	Direction	Speed	Street or road other auto was driving on	Direction	Speed

Were your lights on?			Were the other auto's lights on?			Traffic controls in place?	For whom?	Speed Limit
Y	Bright	Dim	Y	Bright	Dim			
N			N					

Did either driver give signal of any kind?		If intersection who entered first?	Who had right of way?
Y	If yes, who?		
N			

Describe how the accident happened. Include any special details of the collision. Attach additional sheets if needed.

Show on the diagram the position of all autos, persons, traffic controls (stop lights, stop signs, etc.) and other objects. Show street names.

My Auto

Other Auto

Third Auto

Stop sign

Yield sign

Traffic light

Your Auto's Glass Breakage

Type of glass:	Tinted	Safety	Type of break	Cracked	Chipped or pitted
	Clear	Plate	Shattered	Bull's eye	Half moon

Location of breakage Windshield	Vent	Rear	Door	Other (describe)

Windshield damage: check "Type of glass" and "Type of break", above, and mark location on diagram

Do you think a claim will be made against you?		By whom?
Y	Uncertain	
N		

Who is your supervisor?	
Your supervisor's phone number	
What is your title / position?	Your signature
	Date
Your phone number	Your email address

NOTE: When submitting this form electronically, your initials below will serve as your electronic signature.

Reported to (Name)	Initials	Reported by (Name)	Initials	Date reported

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