



CLAIMANT AUTO ACCIDENT REPORT

For Completion by Driver

DEPARTMENT OF ADMINISTRATIVE SERVICES

RISK MANAGEMENT, 1225 FERRY ST SE U150, SALEM OR 97301-4287

Risk Management Division must receive your claim within 180 days from the date of loss, per ORS 30.275.

Driver or Claimant Information

Driver _____ Age _____ Res. Phone _____ Bus. Phone _____

Address _____ City _____ State _____ Zip _____

Driver's License Number _____ State of Issue _____ Vehicle Plate # _____

Year _____ Make _____ Model _____

Owner _____ Res. Phone _____ Bus. Phone _____

Address _____ City _____ State _____ Zip _____

For what purpose was car being used at time of accident? _____

Has damage been repaired? Yes No If yes, by whom? _____

If not, estimated cost to repair _____ By whom? _____

Is car insured? Yes No If yes, company name and policy number _____

State Veh.

Year _____ Make _____ Model _____ Vehicle Plate # _____

State Agency _____ Address _____

State Driver _____ Bus. Phone _____

Address _____ City _____ State _____ Zip _____

Injuries

Was anyone injured or complained of being hurt? Yes No

	Name	Address	Phone	Age	Which Car			Nature of Injuries
					A	B	Other	
1.								
2.								
3.								

Witnesses

	Name(s)	Address	Phone	Which Car		
				A	B	Other
1.						
2.						
3.						

Incident

Date _____ Time _____ a.m. p.m. Daylight Dark Artificial Lights Weather condition _____

Location _____ City _____ State _____

Your Direction _____ Other Car (Ped.) Direction _____

Your Speed _____ Others Speed _____ Who had right of Way? _____

Did you see other car before collision? Yes No Where? _____

How far from collision was your car at that time? _____

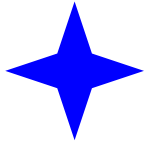
What signals did you give? _____ Other Driver? _____

Who investigated? _____ Who Cited and Why? _____

Describe Accident _____

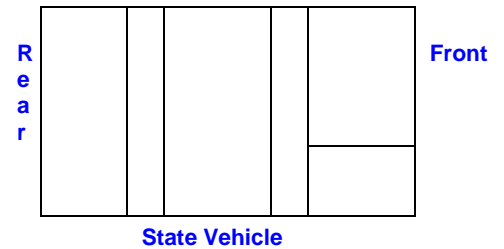
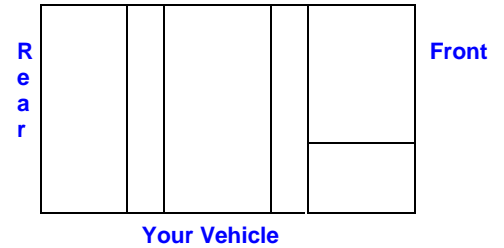
CONTINUE ON REVERSE SIDE

D I A G R A M T H E A C C I D E N T S C E N E :



COMPASS ↑

Indicate points
of compass:
N E S W



INSTRUCTIONS:

Give street names, directions, and locations of objects involved.

- (1) Letter each vehicle (your vehicle A, state vehicle B) and show direction of travel by arrow → ←
- (2) Use solid line to show path of each vehicle before accident → dotted line after accident→
- (3) Show motorcycle or bicycle by → ○-○ (4) Show pedestrian by → ○ (5) Show railroad by → | | | | | | | | | |
- (6) Show witness by → W

ADDITIONAL FACTS: (i.e. if multiple cars, list others here, any information that was not covered on the form you want to add, etc.)

PLEASE INCLUDE: Pictures (if available). Two estimates from shops (where you would be willing to have your vehicle repaired). These may be required if your claim is accepted for payment. For windshield damage, include an estimate from an auto glass shop. **Risk Management must receive your claim within 180 days from the date of loss, per ORS 30.275.**

Signature of Driver _____ Date _____
 If driver is a minor, signature of driver's guardian _____ Date _____

Return completed form to:

Department of Administrative Services
 Risk Management
 1225 Ferry St SE U150
 Salem OR 97301-4287
 PHONE: (503) 373-7475
 FAX: (503) 373-7337