

AT THE SCENE OF AN ACCIDENT FORM
AT THE SCENE. FILL OUT THE BELOW INFORMATION

ORS 811.700 **REQUIRES** DRIVERS INVOLVED IN AN ACCIDENT TO EXCHANGE THE BELOW INFORMATION.
 ORS 811.715 **REQUIRES** WITNESSES TO PROVIDE THEIR CONTACT INFO (give witnesses enclosed ORANGE Witness Cards at the scene).

AS SOON AS SAFELY POSSIBLE

- Contact **OSU Risk Management** at **541-737-7252** or risk@oregonstate.edu **IMMEDIATELY** if this was a serious accident (i.e. ambulance involved, vehicle towed). If this is an OSU Motor Pool vehicle, also call 541-737-4141.
- If OSU Risk not available, **LEAVE MESSAGE**. You may also call the State of Oregon Risk Division **503-373-7475**.
- If required, complete the DMV "Oregon Traffic Accident and Insurance Report" (required for accidents with ANY injury, when a vehicle is towed, and/or if damages exceed \$1,500). **IT IS YOUR RESPONSIBILITY** to send the original of this form to DMV within **72 hours**.
- Make two copies of the DMV report. Keep one copy and submit one with the State Self Insurance Claim Form.
- Complete the enclosed **State Self Insurance Claim Form**. Give to Motor Pool (for Motor Pool vehicles) and/or your Supervisor (for other vehicles) for submission to: **OSU Risk Management**
Mail: 644 SW 13th St.; Corvallis, OR 97333; Fax: 541-737-5546; email: risk@oregonstate.edu
- **RESTOCK** this Accident Report Packet by contacting OSU Risk Management or with forms found online at <http://risk.oregonstate.edu>; Toolkits (NOTE: Make sure forms are **color-coded** when restocking from website.)

OSU IS SELF INSURED THROUGH THE STATE OF OREGON INSURANCE FUND.
 (PROOF OF INSURANCE IS THE BLUE CERTIFICATE OF COVERAGE FORM)

DRIVER OF OSU VEHICLE
FILL OUT AT SCENE OF ACCIDENT

DRIVER'S NAME	WORK PH #
AGENCY #: 580300 OREGON STATE UNIV SUPERVISOR	DEPT.
YR & MAKE OF VEHICLE	DR. LIC # & ST
DATE	OSU PLATE #
ACCIDENT LOCATION, STREET INTERSECTION, CITY	TIME AM/PM
ESTIMATED DAMAGE TO OSU VEHICLE	
YOUR INJURIES, IF ANY	
PASSENGERS IN YOUR VEHICLE:	
NAME #1	PH #
ADDRESS	
INJURIES, IF ANY	
NAME #2	PH #
ADDRESS	
INJURIES, IF ANY	
BRIEFLY EXPLAIN HOW ACCIDENT HAPPENED:	

DRIVER OF OTHER VEHICLE
**GET INFO FROM DRIVER'S LICENSE AND
 REGISTRATION, IF POSSIBLE**

DRIVER'S NAME	PH #
STREET ADDRESS	
CITY, ST, ZIP	DR. LIC # & ST
YR & MAKE OF VEHICLE	PLATE #
ESTIMATED DAMAGE	CAR <input type="checkbox"/>
	TRUCK <input type="checkbox"/>
INJURIES TO DRIVER, IF ANY	
INSURANCE COMPANY	
POLICY #	
CONTACT INFO (AGENT, PH #)	
PASSENGERS IN OTHER VEHICLE:	
NAME #1	PH #
ADDRESS	
INJURIES, IF ANY	
NAME #2	PH #
ADDRESS	
INJURIES, IF ANY	

**PROVIDE ANY ADDITIONAL INFO/COMMENTS
 ON BACK OF THIS FORM.**