



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)

Page of

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		JOB TITLE	BUSINESS TELEPHONE	

STATE VEHICLE	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL	VEHICLE OWNER		DEPT. VEHICLE NO. (Optional)
	DESCRIBE DAMAGES TO STATE VEHICLE		ESTIMATED REPAIR COST	<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

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
	BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY			WORK TELEPHONE		
					NAME AND ADDRESS OF OTHER PARTY'S INSURANCE	

INJURED	NAME	AGE	ADDRESS	HOSPITAL
	NAME	AGE	ADDRESS	HOSPITAL

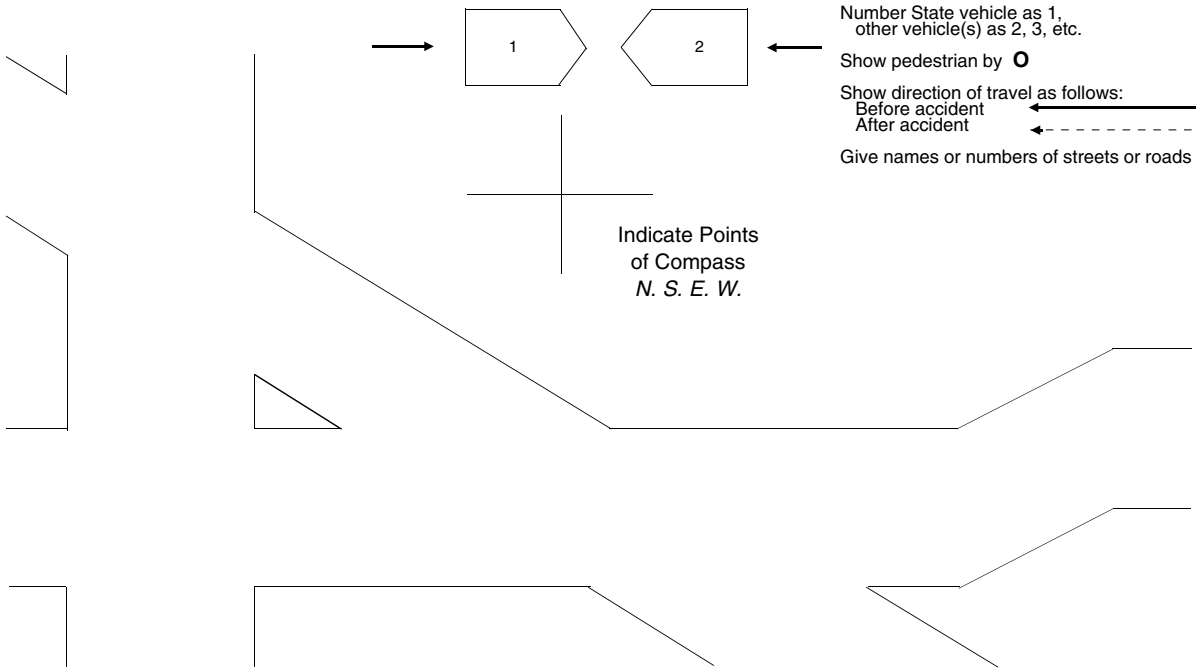
WITNESS	NAME	TELEPHONE	ADDRESS
	NAME	TELEPHONE	ADDRESS

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

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