

CONFIDENTIAL: CLAIM INVESTIGATIVE MATERIALS

COMMONWEALTH OF VIRGINIA

Automobile Incident Report

Vehicle Pool Number

Complete this form and email it to DRMClaims@trs.virginia.gov or send by fax: 804-371-2442

If available, include a copy of the police report

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

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	Location Street or highway		City /County		State	
		A.M. P.M.						
BY THE TERMS OF THE AGENCY'S COVERAGE THE COMMONWEALTH MUST BE GIVEN A REASONABLE OPPORTUNITY TO EXAMINE YOUR AUTO BEFORE REPAIRS ARE MADE.								
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						
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	

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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.								
Your Auto's Glass Breakage	Type of glass:		Tinted	Safety	Type of break		Cracked	Chipped or pitted	
			Clear	Plate			Shattered	Bull's eye	
	Location of breakage		Vent	Rear	Door	Other (describe)			
	Windshield								
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 signature Date Your email address					
Your supervisor's phone number									
What is your title / position?									
Your phone number									
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	