

**VIRGINIA TECH
AUTOMOBILE ACCIDENT REPORT**

CALL THE POLICE

When an accident occurs, follow the instructions on the envelope provided in your glove compartment.
Any questions should be referred to Virginia Tech Risk Management at 540-231-7439.

DO NOT DISCUSS ACCIDENT WITH ANYONE EXCEPT VIRGINIA TECH RISK MANAGEMENT, INSURANCE COMPANY REPRESENTATIVE OR THE POLICE.

POLICY-HOLDER	NAME VIRGINIA TECH, RISK MANAGEMENT					POLICY NUMBER C900093	
	ADDRESS: STREET CITY STATE ZIP CODE Mail Code 0310, Blacksburg, Virginia 24061					PHONE NUMBER 540-231-7439 FAX: 540-231-5064	
TIME AND PLACE OF ACCIDENT	DATE OF ACCIDENT	HOUR	A.M. P.M.	LOCATION	STREET OR HIGHWAY	CITY	COUNTY STATE
ABOUT YOUR AUTO (#1)	MAKE OF AUTO	YEAR	BODY TYPE	VEHICLE IDENTIFICATION NUMBER		LICENSE PLATE NUMBER	
	NAME OF DRIVER AND PHONE NUMBER			ADDRESS: STREET		CITY	STATE ZIP CODE
	DEPARTMENT NAME			DEPARTMENT SUPERVISOR'S NAME & PHONE NUMBER			
	E-MAIL ADDRESS		VIRGINIA TECH ID #		WAS LICENSE IN EFFECT AT TIME OF ACCIDENT?		
	WAS AUTO BEING OPERATED FOR BUSINESS OR PLEASURE? <input type="checkbox"/> BUSINESS <input type="checkbox"/> PLEASURE		WHO GAVE PERMISSION?		WAS AUTO BEING USED FOR ERRAND FOR OWNER?		
	DESCRIBE PARTS DAMAGED AND EXTENT OF DAMAGE.						
	WHERE MAY AUTO BE SEEN?		ESTIMATED COST OF REPAIRS		WHERE IS VEHICLE NORMALLY GARAGED ? (CITY & STATE)		
OTHER AUTO INVOLVED (#2)	MAKE OF AUTO	YEAR	LICENSE NUMBER	ESTIMATED COST OF REPAIRS			
	PARTS DAMAGED AND EXTENT OF DAMAGE						
	OWNER'S NAME & PHONE NUMBER			ADDRESS: STREET		CITY	STATE ZIP CODE
	DRIVER'S NAME & PHONE NUMBER <input type="checkbox"/> SAME			ADDRESS: STREET		CITY	STATE ZIP CODE
	IS AUTO INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF INSURANCE COMPANY			POLICY NUMBER	INSURANCE COMPANY PHONE NUMBER	
PASSENGERS	NAMES OF PASSENGERS IN AUTO (#1)			ADDRESSES: STREET		CITY	STATE ZIP CODE
	NAMES OF PASSENGERS IN AUTO (#2)			ADDRESSES: STREET		CITY	STATE ZIP CODE
INJURIES (No Matter How Minor)	NAMES OF PERSONS INJURED		AUTO #	ADDRESSES		INJURIES	AGE
	NAME OF DOCTOR OR HOSPITAL			ADDRESSES: STREET		CITY	STATE ZIP CODE
WITNESSES	NAMES			ADDRESSES: STREET		CITY	STATE ZIP CODE PHONE NUMBER

DESCRIP- TION OF ACCIDENT	ON WHAT STREET WERE YOU DRIVING?	DIRECTION	SPEED	STREET OR ROAD OTHER AUTO WAS DRIVING ON?	DIRECTION	SPEED	
	WERE YOUR LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM	WERE OTHER AUTO'S LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM	WHAT TRAFFIC CONTROLS?		FOR WHOM	SPEED LIMIT	
	DID EITHER DRIVER GIVE SIGNAL OF ANY KIND? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHO?			IF INTERSECTION, WHO ENTERED FIRST?	WHO HAD RIGHT OF WAY?		
	WHICH DRIVER VIOLATED TRAFFIC ORDINANCE?	CHARGE:	DID POLICE INVESTIGATE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		POLICE ADDRESS?		
	POLICE OFFICER NAME AND/OR BADGE NUMBER			POLICE PHONE NUMBER			
	DESCRIBE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED:						
SHOW ON THE DIAGRAM THE POSITIONS OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTER OBJECTS. SHOW STREET NAMES							
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 40%;"> </div> <div style="width: 55%; border-left: 1px solid black; padding-left: 10px;"> <p>#1 MY AUTO </p> <p>#2 OTHER AUTO </p> <p>THIRD AUTO </p> <p>PEDESTRIAN </p> <p>STOP SIGN </p> <p>YEILD SIGN </p> <p>STOP LIGHT </p> </div> </div>							
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?				
GLASS BREAKAGE	LOCATION OF BREAKAGE: <input type="checkbox"/> DOOR <input type="checkbox"/> VENT <input type="checkbox"/> REAR <input type="checkbox"/> WINDSHIELD <input type="checkbox"/> OTHER - DESCRIBE						
	TYPE OF GLASS <input type="checkbox"/> TINTED <input type="checkbox"/> SAFETY PLATE		TYPE OF BREAK <input type="checkbox"/> CRACKED <input type="checkbox"/> CHIPPED OR PITED		<input type="checkbox"/> CLEAR <input type="checkbox"/> SAFETY PLATE <input type="checkbox"/> SHATTERED <input type="checkbox"/> BULL'S EYE (O) <input type="checkbox"/> HALF MOON ()		
	WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION ON DIAGRAM:						
DATE OF REPORT		SIGNATURE OF DRIVER			REPORTED TO CRAWFORD AND COMPANY <input type="checkbox"/> YES <input type="checkbox"/> NO		

PLEASE SIGN COMPLETED FORM AND RETURN