



COUNTY OF SAN JOAQUIN AUTOMOBILE ACCIDENT

Information Reported Herein is
Considered Privileged and Confidential

Please Print-Fill Out Immediately	Send One Copy to Public Works-Fleet Services and One Copy to Risk Management	Must be Signed by Supervisor							
County Driver	Name of County Driver (Vehicle #1)		Address		Employee ID No.	Age	Driver's License No.		
	Department		Division		Location Code No.		County Phone No.		
	Date of Accident	Time of Accident	Location of Accident (Intersection or Address)			Law Enforcement Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Law Enforcement Report No.	
	<input type="checkbox"/> Sheriff <input type="checkbox"/> City PD <input type="checkbox"/> CHP								
	For What Purpose was Vehicle Being Used at Time of Accident or Loss?								
	County Vehicle No.		Vehicle License No.		County Vehicle Year	County Vehicle Make		County Vehicle Model	
	Describe Damage or Loss/if Theft, Specify Property:							Was County Vehicle Towed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were you Injured? If yes, Part of Body Affected. <input type="checkbox"/> Yes <input type="checkbox"/> No				Describe Your Injury					
Other Driver	Name of Other Driver (Vehicle #2)				Driver's License No.		Phone Number	Age	
	Address				City		State	Zip Code	
	Registered Owner of Vehicle				Vehicle Insured by			Policy No.	
	Registered Owner Address				City		State	Zip Code	
	Other Vehicle License No.		Year	Make		Model		Was Vehicle Towed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe Damage to Other Vehicle				Describe Other Driver's Injury <input type="checkbox"/> None				
	Other Injuries	Injured Person's Name				Age		Phone Number	
Address				City		State	Zip Code		
Describe Injury <input type="checkbox"/> Hospitalized <input type="checkbox"/> Doctor				Passenger Vehicle <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3		Pedestrian Hit By <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3			
Injured Person's Name				Age		Phone Number			
Address				City		State	Zip Code		
Describe Injury <input type="checkbox"/> Hospitalized <input type="checkbox"/> Doctor				Passenger Vehicle <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3		Pedestrian Hit By <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3			
Were Any Injured Persons Transported by Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Witnesses	Witness Name					Phone Number			
	Address					City		State	Zip Code
	Witness Name					Phone Number			
	Address					City		State	Zip Code

