



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
ORIGINAL - INSURANCE MANAGEMENT
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)

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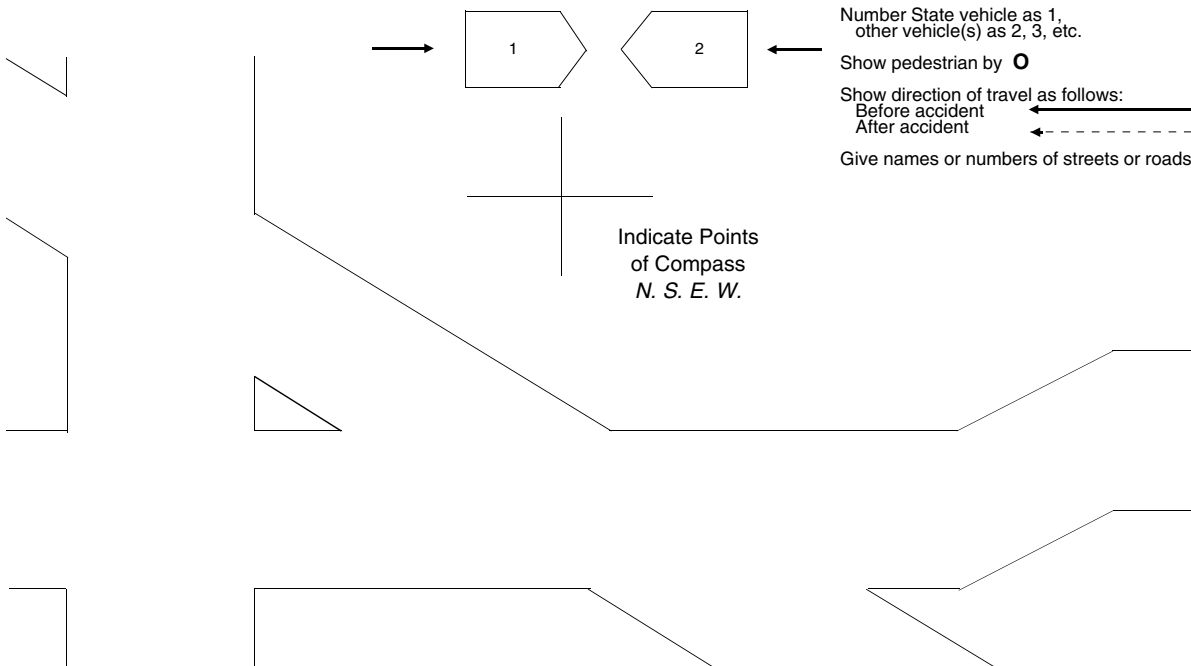
STATE DRIVER	NAME		AGE	EMPLOYING DEPARTMENT		AGENCY BILLING CODE
	DRIVER'S LICENSE NO.		ACCIDENT DATE	TIME	OFFICE ADDRESS	AGENCY DOCUMENT NO. (Optional)
	WAS VEHICLE BEING USED ON OFFICIAL STATE BUSINESS? (If NO, attach explanation) ☐ YES ☐ NO					BUSINESS TELEPHONE
	DATE DRIVER LAST COMPLETED STATE DEFENSIVE DRIVER TRAINING Month/Year ☐ NOT TAKEN					
STATE VEHICLE	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL		VEHICLE OWNER		DEPT. VEHICLE NO. (Optional)
	DESCRIBE DAMAGES TO STATE VEHICLE		ESTIMATED REPAIR COST	☐ DEPARTMENT OWNED ☐ DGS POOL ☐ RENTAL ☐ 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		
				WEATHER CONDITIONS		
	(City/State)			TRAFFIC CONDITIONS		
	(County)			HOW FAST WERE YOU DRIVING?		EST. SPEED OF OTHER CAR
	POLICE REPORT MADE ☐ YES ☐ NO			NAME AND ADDRESS OF INVESTIGATING AGENCY		
	AGENCY ☐ CHP ☐ OTHER					
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
						WORK TELEPHONE
	BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY				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			

(CONTINUE ON REVERSE)

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	
NAME AND ADDRESS OF OTHER PARTY'S INSURANCE CARRIER					
PASSENGER	NAME		AGE	ADDRESS	HOSPITAL
	NAME		AGE	ADDRESS	HOSPITAL
	NAME		ADDRESS		
	NAME		ADDRESS		
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. Employee Signature and Date _____ Reviewing Officer Signature (Supervisor or Safety Coordinator) _____ Type Name and Title of Reviewing Officer _____ Telephone Number of Reviewing Officer _____					