IMPORTANT: Must be completed in Acrobat Reader. Download Reader here

DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Risk Management | EGS
PO Box 12009
Salem, OR 97309-0009
503-373-7475
503-373-7337 fax

E-mail: risk.management@oregon.gov
Website: State of Oregon: Risk Management

Find this form on the Web at:
https://www.oregon.gov/DAS/EGS/Risk/docs/formvehaccclaim.pdf

OREGON AUTO ACCIDENT REPORT FORM

Claimant Information

Name _____ Age _____ Phone _____ Alternate Phone _____

Address _____ City _____ State _____ Zip _____

Driver's License Number _____ State of Issue _____ Vehicle Plate # _____

Year _____ Make _____ Model _____

Owner _____ Res. Phone _____ Bus. Phone _____

Address _____ City _____ State _____ Zip _____

For what purpose was car being used at time of accident? _____

Has damage been repaired? ☐ Yes ☐ No If yes, by whom? _____

If not, estimated cost to repair _____ By whom? _____
(estimates required; see pg 2 for more information)

Is car insured? ☐ Yes ☐ No If yes, company name and policy number _____

State Vehicle

Year _____ Make _____ Model _____ Vehicle Plate # _____

State Agency _____ Address _____

State Driver _____ Bus. Phone _____

Address _____ City _____ State _____ Zip _____

Incident

Date _____ Time _____ ☐ a.m. ☐ p.m.

Who investigated? _____ Who was cited and why? _____

Describe Incident:

Police Report Number: _____

City/Nearest City _____ State _____

Location (mile post, exit number, cross streets, name of highway)

Witnesses

Name	Address	Phone	Car (state vehicle, other)
1.			
2.			
3.			

Injuries

Was anyone injured or complained of being hurt? ☐ Yes ☐ No

Name	Address	Phone	Age	Car	Nature of injuries
1.					
2.					
3.					

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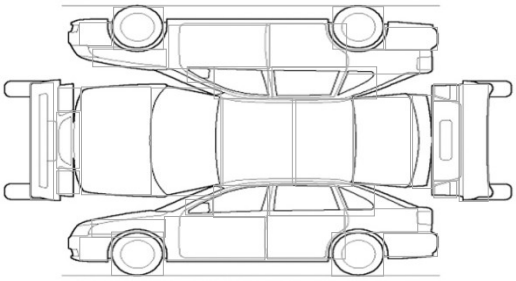
D I A G R A M T H E A C C I D E N T S C E N E :

Right

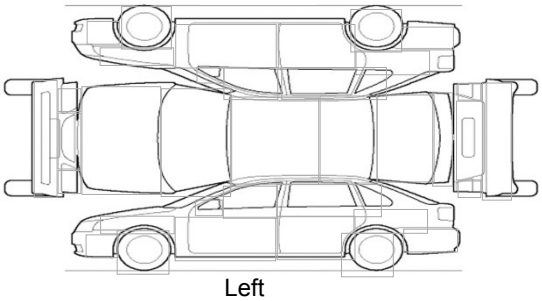


Left

State Car

Please mark the damaged areas on the corresponding vehicles.

Right



Left

Other car: _____

_____

Check all that apply

Conditions: *(check one)*	Type of Incident:	Incident occurred on:	Were there flashing lights or warning signs?	What was your vehicle doing in relation to the other vehicle?	If your vehicle was damaged from rocks or debris, where did they come from?	How fast were you driving?
☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark ☐ Artificial lights ☐ Other:	☐ Sanding ☐ Pothole ☐ Resurfacing ☐ Collision ☐ Other:	☐ Straight road ☐ Curve ☐ Uphill ☐ Downhill ☐ Intersection ☐ Parking lot ☐ One lane ☐ 2 lanes ☐ 4 lanes ☐ Other:	☐ Yes ☐ No Did you have a traffic control signal? ☐ Red ☐ Green ☐ Yellow ☐ None	☐ Passing ☐ Following ☐ Parked ☐ Approaching from the opposite direction ☐ Turning ☐ Other:	☐ Road surface ☐ Vehicle tire ☐ Load ☐ Unknown ☐ Other:	Your speed? _____ mph Did you see other car before collision? ☐ Yes ☐ No
Weather:						

I declare the foregoing is true and correct to the best of my knowledge.

Signature of claimant:_____ Date:_____

PLEASE SUBMIT photos and a diagram of the incident with this claim form. This documentation may also be submitted by mail. Two estimates from shops where you would be willing to have your vehicle repaired are required if your claim is accepted for payment. If your damage is windshield damage, one of the two estimates must be from an auto glass shop. Per ORS 30.275, Risk Management must receive your claim within 180 days from the date of loss.

Signature of Driver_____ Date_____

If driver is a minor, signature of driver's guardian_____ Date_____

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Bodily Injury Questionnaire: **IMPORTANT: We are required by federal law to obtain the information in questions 15 through 17. Failure to provide this information will result in delays in resolving your claim. You can find further information at Centers for Medicare and Medicaid Services - Home Website.**

Bodily Injury Questionnaire

15. Last Name | First name | Middle initial

16. Date of Birth (mm/dd/yyyy) | 17. Gender ☐M ☐F

18. Is this related to an auto accident? (If no, skip to question 22)

19. If yes, where were you seated in vehicle?

☐Driver ☐Front right passenger ☐Rear right passenger ☐Rear left passenger ☐Other _____

20. Seatbelt used? ☐Yes ☐No What kind? ☐Lap ☐Shoulder ☐None

21. Did the airbag deploy? ☐Yes ☐No

22. Describe your injury:

23. When did you first notice you were injured?

24. Have you sought medical treatment? ☐Yes ☐No 25. If yes, list the medical providers you have seen:

26. Approximate amount of medical costs incurred to date:

27. Is future treatment expected? ☐Yes ☐No 28. If yes, explain:

29. Do you have any prior injuries to the injured body part(s)? ☐Yes ☐No 30. If yes, explain:

31. Any other information you would like to provide to us:

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Additional information:

PRINT SUBMIT

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