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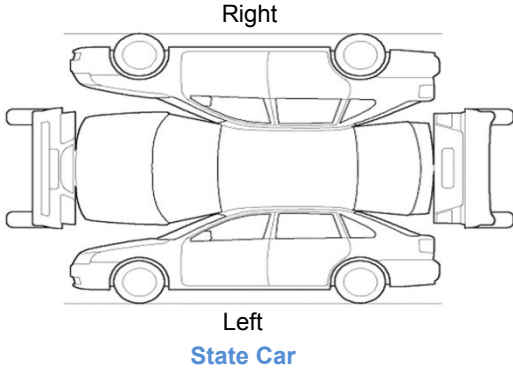
Find this form on the Web at:
<https://www.oregon.gov/DAS/EGS/Risk/docs/formvehacclaim.pdf>

OREGON AUTO ACCIDENT REPORT FORM

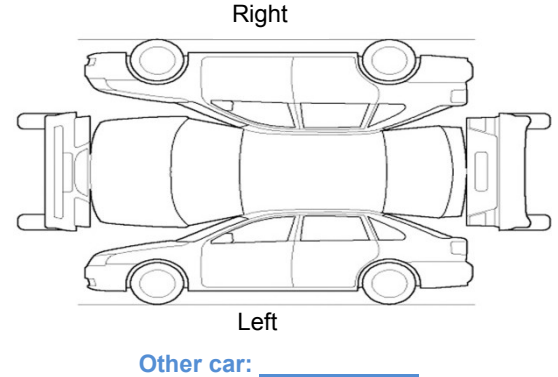
Claimant Information	Name _____ Age _____ Phone _____ Alternate Phone _____			
	Address _____ City _____ State _____ Zip _____			
	Driver's License Number _____ State of Issue _____ Vehicle Plate # _____			
	Year _____ Make _____ Model _____			
	Owner _____ Res. Phone _____ Bus. Phone _____			
	Address _____ City _____ State _____ Zip _____			
	For what purpose was car being used at time of accident? _____			
	Has damage been repaired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom? _____			
If not, estimated cost to repair _____ By whom? _____ <small>(estimates required; see pg 2 for more information)</small>				
Is car insured? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 :



Please mark the
 damaged areas on
 the corresponding
 vehicles.



Check all that apply

Conditions: <i>(check one)</i> <input type="checkbox"/> Daylight <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark <input type="checkbox"/> Artificial lights <input type="checkbox"/> Other:	Type of Incident: <input type="checkbox"/> Sanding <input type="checkbox"/> Pothole <input type="checkbox"/> Resurfacing <input type="checkbox"/> Collision <input type="checkbox"/> Other:	Incident occurred on: <input type="checkbox"/> Straight road <input type="checkbox"/> Curve <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill <input type="checkbox"/> Intersection <input type="checkbox"/> Parking lot <input type="checkbox"/> One lane <input type="checkbox"/> 2 lanes <input type="checkbox"/> 4 lanes <input type="checkbox"/> Other:	Were there flashing lights or warning signs? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you have a traffic control signal? <input type="checkbox"/> Red <input type="checkbox"/> Green <input type="checkbox"/> Yellow <input type="checkbox"/> None	What was your vehicle doing in relation to the other vehicle? <input type="checkbox"/> Passing <input type="checkbox"/> Following <input type="checkbox"/> Parked <input type="checkbox"/> Approaching from the opposite direction <input type="checkbox"/> Turning <input type="checkbox"/> Other:	If your vehicle was damaged from rocks or debris, where did they come from? <input type="checkbox"/> Road surface <input type="checkbox"/> Vehicle tire <input type="checkbox"/> Load <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	How fast were you driving? Your speed? _____ mph Did you see other car before collision? <input type="checkbox"/> Yes <input type="checkbox"/> 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 estimated 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 <input type="checkbox"/> M <input type="checkbox"/> F	
	18. Is this related to an auto accident? (If no, skip to question 22)		
	19. If yes, where were you seated in vehicle? <input type="checkbox"/> Driver <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Other _____		
	20. Seatbelt used? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? <input type="checkbox"/> Lap <input type="checkbox"/> Shoulder <input type="checkbox"/> None		
	21. Did the airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	22. Describe your injury:		
	23. When did you first notice you were injured?		
	24. Have you sought medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		28. If yes, explain:
	29. Do you have any prior injuries to the injured body part(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		30. If yes, explain:
	31. Any other information you would like to provide to us:		

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Additional information:

PRINT

EMAIL