

**VEHICLE ACCIDENT REPORT**

STD 270 (Rev. 10/2019)

**\*\*CONFIDENTIAL INFORMATION\*\*****DO NOT RELEASE TO OTHER PARTIES WITHOUT CONSENT OF  
THE OFFICE OF RISK AND INSURANCE MANAGEMENT.***This report must be received by ORIM within 2 business days after accident.*DEPARTMENT OF GENERAL SERVICES  
OFFICE OF RISK AND INSURANCE MANAGEMENT  
916.376.5300  
claims@dgs.ca.gov**STATE DRIVER**

NAME			EMPLOYING DEPARTMENT		
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	JOB TITLE		
STATE DRIVER'S EMAIL			OFFICE ADDRESS (Street, City, State, Zip Code)		
WAS VEHICLE BEING USED ON OFFICIAL STATE BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, attach explanation)			SUPERVISOR NAME		
DATE LAST STATE DEFENSIVE DRIVER TRAINING COMPLETED: _____ <input type="checkbox"/> NOT TAKEN			SUPERVISOR EMAIL		SUPERVISOR PHONE

**STATE VEHICLE**

VEHICLE LICENSE NUMBER	VEHICLE YEAR	MAKE	MODEL	VEHICLE EQUIPMENT NUMBER	
VEHICLE OWNER: Indicate Dept. Owned*, Rental*, DGS Pool, or Employee Owned				* If Dept. Owned or Rental, Enter Owner's Name	
DESCRIBE DAMAGES TO STATE VEHICLE					

**ACCIDENT DETAILS**

ACCIDENT LOCATION (Address/Area)			ACCIDENT DATE	ACCIDENT TIME	HOW FAST WERE YOU DRIVING?	EST. SPEED OF OTHER VEHICLE
			ROAD CONDITIONS		POLICE REPORT MADE? YES: <input type="checkbox"/> NO: <input type="checkbox"/>	
CITY	STATE	ZIP CODE	WEATHER CONDITIONS		INVESTIGATING AGENCY NAME AND ADDRESS	
COUNTY			TRAFFIC CONDITIONS			
FULLY STATE HOW THE ACCIDENT OCCURRED						

**OTHER VEHICLE**

DRIVER'S NAME			VEHICLE LICENSE NO.	VEHICLE YEAR	MAKE	MODEL
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	REGISTERED OWNER		OWNER PHONE	NO. OF PASSENGERS
DRIVER'S ADDRESS			OWNER ADDRESS (Street, City, State, Zip Code)			
CITY			STATE	ZIP	NAME AND POLICY NUMBER OTHER PARTY'S INSURANCE	
BRIEFLY DESCRIBE DAMAGE TO OTHER VEHICLE/PROPERTY						

**VEHICLE ACCIDENT REPORT**

STD 270 (Rev. 10/2019)

**\*\*CONFIDENTIAL INFORMATION\*\*****DO NOT RELEASE TO OTHER PARTIES WITHOUT CONSENT OF  
THE OFFICE OF RISK AND INSURANCE MANAGEMENT.***This report must be received by ORIM within 2 business days after accident.***INJURED**

NAME	DATE OF BIRTH	ADDRESS (Street, City, State, Zip Code)
NAME	DATE OF BIRTH	ADDRESS (Street, City, State, Zip Code)

**WITNESS**

NAME	PHONE	ADDRESS (Street, City, State, Zip Code)
NAME	PHONE	ADDRESS (Street, City, State, Zip Code)

**ADDITIONAL VEHICLE**

DRIVER'S NAME			VEHICLE LICENSE NO.	VEHICLE YEAR	MAKE	MODEL
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	REGISTERED OWNER			OWNER PHONE
DRIVER'S ADDRESS (Street, City, State, Zip Code)			OWNER ADDRESS (Street, City, State, Zip Code)			

NAME AND POLICY NUMBER OTHER PARTY'S INSURANCE

DESCRIBE DAMAGE TO OTHER VEHICLE/PROPERTY