STATE OF CALIFORNIA

VEHICLE ACCIDENT REPORT

STD 270 (Rev. 1/2025)

OFFICE OF RISK AND INSURANCE MANAGEMENT 916.376.5300 claims@dgs.ca.gov

DEPARTMENT OF GENERAL SERVICES

CONFIDENTIAL INFORMATION

DO NOT RELEASE TO OTHER PARTIES WITHOUT CONSENT OF THE OFFICE OF RISK AND INSURANCE MANAGEMENT.

STATE DRIVER	Triis rep	on must be received	u by Orthin within 2 business t	ays and addition.					
NAME	EMPLOYING DEPA	EMPLOYING DEPARTMENT							
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	JOB TITLE	JOB TITLE					
STATE DRIVER'S EMAIL			OFFICE ADDRESS (OFFICE ADDRESS (Street, City, State, Zip Code)					
WAS VEHICLE BEING USED ON OF	SUPERVISOR NAMI	SUPERVISOR NAME							
YES NO (If	NO, attach explan	ation)	SUPERVISOR EMAIL	SUPERVISOR EMAIL		UPERVISOR PHONE			
STATE VEHICLE									
VEHICLE VEHICL LICENSE NUMBER YEAR	E MAKE	MODEL	VEHICLE EQUIPMEN	VEHICLE EQUIPMENT NUMBER					
VEHICLE OWNER: Indicate Dept. Owned	yee * If Dept. Owned or	* If Dept. Owned or Rental, Enter Owner's Name							
DESCRIBE DAMAGES TO STATE V	EHICLE								
ACCIDENT DETAILS	va a \	ACCIDENT DATE		DOLLOE DE	DODT MADEO				
ACCIDENT LOCATION (Address/Area)		ACCIDENT DATE		PULICE RE	POLICE REPORT MADE?				
		ACCIDENT TIME			YES: NO:				
CITY	STATE ZIP CODE	INVESTIGATING AGENCY NAME AND ADDRESS							
COUNTY	1								
PROVIDE A BRIEF DESCRIPTION	OF HOW THE ACCID	ENT OCCURED							
OTHER VEHICLE									
DRIVER'S NAME			VEHICLE LICENSE NO.	VEHICLE YEAR	MAKE	MODEL			
DRIVER'S LICENSE NUMBER	ATE OF BIRTH	PHONE	REGISTERED OWNE	। २	OWNER PHONE	NO. OF PASSENGERS			
DRIVER'S ADDRESS			OWNER ADDRESS (OWNER ADDRESS (Street, City, State, Zip Code)					
CITY		STATE ZIP	NAME AND POLICY I	NAME AND POLICY NUMBER OTHER PARTY'S INSURANCE					
BRIEFLY DESCRIBE DAMAGE TO (THER VEHICLE/PRO	DPERTY							

STATE OF CALIFORNIA

VEHICLE ACCIDENT REPORT

STD 270 (Rev. 11/2024)

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK AND INSURANCE MANAGEMENT
916.376.5300
claims@dgs.ca.gov

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 OWNE	REGISTERED OWNER O'			
DRIVER'S ADDRESS (Street, City, State, Zip Code)			OWNER ADDRESS (Street, City, State, Zip Code)				
NAME AND POLICY NUMBER OTHE	ER PARTY'S INSURANCE	<u> </u>					
DESCRIBE DAMAGE TO OTHER VE	EHICLE/PROPERTY						