

SCHOOLS INSURANCE AUTHORITY

(Effective of 07/01/2015)

P.O. Box 276710
Sacramento, CA 95827-6710
916/364-1281
Fax 916/ 362-0904

AUTOMOBILE ACCIDENT REPORT (To Be Completed By District Employees ONLY)

FOR USE BY DISTRICTS AND SIA ONLY – DISTRIBUTE ONLY TO DISTRICT AND SIA

Coverage/Limits: Comprehensive Deductible **\$500.00** If Damage to district vehicle exceeds deductible – NO repairs are to be made without notifying SIA
Collision Deductible **\$1000.00**

Name of District: Name of School District _____
Name of Department _____
Name of Driver: _____
Driver's License #: _____
Driver Phone Number: Home _____
Work _____
Driver Address: _____

District vehicle: Make of vehicle _____ Model of Vehicle _____
Year of vehicle _____ License # _____
District vehicle # _____

Damage to District Vehicle Location of Vehicle _____
Estimated damage amount _____
Has estimate been completed? **If yes, please attach a copy.** _____
Contact person for Inspection _____
Contact phone number _____
Location of damage on vehicle _____

Date & Time of Accident Date of accident _____ Time of Accident _____ am/pm
Street location _____
City or town _____

Police/Fire Notified Which Agency? CHP - Sheriff - Police - Fire - Paramedics **(Circle one)**
Officer Badge # _____
Report Number _____

Other Vehicle/ Property Damaged Driver Name _____
Driver Address _____
Driver Phone #: _____
Vehicle License # _____
Year /Make/Model of Vehicle _____
Damaged Area _____
of Occupants in Vehicle _____
Insurance information _____ Policy # _____

Injured person Name _____
Nature of Injury _____
Approx. Age _____
In which vehicle was injured located? _____ District _____ Other party _____

PLEASE COMPLETE BACK OF FORM

**FULL
DETAILS
Of**

Accident: State in your own words how the accident occurred: _____

· _____
· _____
· _____
· _____
· _____
· _____
· _____
· _____

Who in your opinion was at fault? _____
Why? _____

DIAGRAM

Witnesses: **Name:** _____ **Name:** _____
 Phone Number: _____ **Phone Number:** _____
 Address: _____ **Address:** _____

Witnesses: **Name:** _____ **Name:** _____
 Phone Number: _____ **Phone Number:** _____
 Address: _____ **Address:** _____

I Hereby Certify That the Foregoing is True to the Best of My Knowledge.

Signature of District Driver _____ Date _____

Signature of Supervisor _____ Date _____

Print Name of Supervisor _____

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PRESENTATION OF A FALSE CLAIM IS A FELONY