



**EMPLOYEE AUTOMOBILE
ACCIDENT REPORT**

ORM CASE NO. _____

1	SUBMIT ORIGINAL SIGNED REPORT TO:		Department of Administrative Services, Office of Risk Management 4200 Surface Road, Columbus, Ohio 43228-1395		
	AGENCY/DEPARTMENT:				
2	SUPERVISOR:			PHONE NO.: ()	
	ADDRESS:			CITY:	
3	TIME & PLACE	DATE OF ACCIDENT:		TIME:	COUNTY:
		LOCATION (BE SPECIFIC):			INVESTIGATING AGENCY:
		REPORT NO.	WHO WAS CITED:		CITATION ISSUED:
	STATE VEHICLE: (UNIT 1)				
	OPERATOR:			WORK PHONE NO.: ()	
	ADDRESS:		CITY	STATE	ZIP
4	S.S. NO.:		OPERATOR'S LIC. NO.:		STATE LICENSE NO.:
	VEHICLE YEAR:	MAKE:	MODEL:	SERIAL NO.:	
	DAMAGE: <input type="checkbox"/> NONE <input type="checkbox"/> DRIVEABLE <input type="checkbox"/> NOT DRIVEABLE			PART OF CAR DAMAGED?:	
	WHAT SPECIFIC JOB ASSIGNMENT WERE YOU PERFORMING AT THE TIME OF THE ACCIDENT?:				
	OTHER VEHICLE (UNIT 2)				
	OR			<u>Check One</u>	
	PROPERTY DAMAGE TO OTHERS: * <input type="checkbox"/> YES (EXPLAIN) <input type="checkbox"/> NO			<input type="checkbox"/> Pedestrian VEHICLE LICENSE NO.: _____	
				<input type="checkbox"/> Driver	
	DRIVER'S NAME:				
	HOME PHONE NO.: ()			WORK PHONE NO.: ()	
	ADDRESS:		CITY	STATE	ZIP
	OWNER'S NAME			INS. CO.:	
5	ADDRESS:		CITY	STATE	ZIP
	VEHICLE YEAR:	MAKE:	MODEL:	BODY STYLE:	COLOR:
	DAMAGE: <input type="checkbox"/> NONE <input type="checkbox"/> DRIVEABLE <input type="checkbox"/> NOT DRIVEABLE				
	PART OF CAR DAMAGED?: <input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> Rt. Front <input type="checkbox"/> Lt. Front <input type="checkbox"/> Rt. Side <input type="checkbox"/> Lt. Side <input type="checkbox"/> Rt. Rear <input type="checkbox"/> Lt. Rear <input type="checkbox"/> Windshield <input type="checkbox"/> Undercarriage				
	DESCRIBE PROPERTY DAMAGE TO OTHERS (i.e.: mailbox, tree, building):				

Use reverse side for DESCRIPTION OF ACCIDENT, Witnesses., injured persons, diagram, and other information of importance in reporting this accident.

GIVE NAMES OF ALL PERSONS INJURED:

NAME:				AGE:	
ADDRESS:	CITY	STATE	ZIP		
NAME:				AGE:	
ADDRESS:	CITY	STATE	ZIP		
NAME:				AGE:	
ADDRESS:	CITY	STATE	ZIP		

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HOW ACCIDENT OCCURRED:

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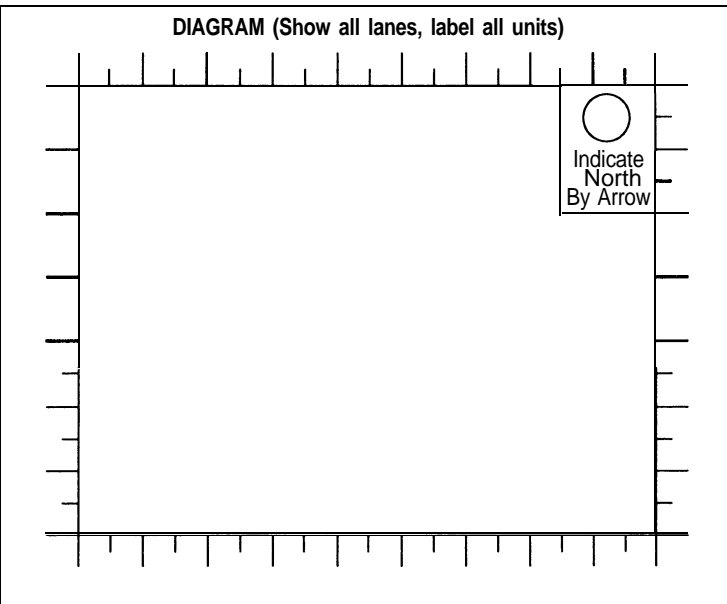
WHOM DO YOU CONSIDER AT FAULT AND WHY?:

DO YOU THINK YOU WERE: <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> 66% <input type="checkbox"/> 75% <input type="checkbox"/> 100% at Fault	DO YOU THINK THE OTHER CAR WAS: <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> 66% <input type="checkbox"/> 75% <input type="checkbox"/> 100% at Fault
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GIVE NAMES OF ALL WITNESSES:

NAME:				PHONE:	
ADDRESS:	CITY	STATE	ZIP		
NAME:				PHONE:	
ADDRESS:	CITY	STATE	ZIP		

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UNIT 1	UNIT 2
Seat Belts Used	Seat Belts Used
Yes	Yes
No	No

DATE OF ACCIDENT:	CASE NO.:
AGENCY/DEPARTMENT:	
SIGNATURE OF DRIVER:	DATE: