Print Clear

STATE OF CALIFORNIA - DGS ORIM

VEHICLE ACCIDENT REPORT

STD. 270 (REV. 2/2002c)

ACCIDENT PREVIOUSLY REPORTED TO ORIM? *(If Yes, give date)*
☐ YES ☐ NO _____

THIS REPORT MUST BE MAILED WITHIN 48 HOURS AFTER ACCIDENT (ACCIDENTS INVOLVING INJURY SHOULD FIRST BE CALLED OR FAXED TO ORIM AT (916) 376-5302 - CALNET 480-5302 - FAX (916) 376-5277.)

**** CONFIDENTIAL INFORMATION ****

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

DISTRIBUTION:
ORIGINAL - **OFFICE OF RISK AND INSURANCE MANAGEMENT 707 THIRD STREET, FIRST FLOOR WEST SACRAMENTO, CA 95605**
COPY - **STATE GARAGE** *(DGS pool vehicle only)*
COPY - **DEPT. FILES** *(Dept. owned vehicles only)*
COPY - **STATE DRIVER** *(Dept. owned vehicles only)*

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STATE DRIVER

NAME		AGE	EMPLOYING DEPARTMENT	AGENCY BILLING CODE
DRIVER'S LICENSE NO.	ACCIDENT DATE	TIME	OFFICE ADDRESS	AGENCY DOCUMENT NO. *(Optional)*
WAS VEHICLE BEING USED ON OFFICIAL STATE BUSINESS? *(If NO, attach explanation)* ☐ YES ☐ NO				
DATE DRIVER LAST COMPLETED STATE DEFENSIVE DRIVER TRAINING *Month/Year* ☐ NOT TAKEN			JOB TITLE	BUSINESS TELEPHONE

STATE VEHICLE

VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL		VEHICLE OWNER ☐ DEPARTMENT OWNED ☐ DGS POOL ☐ RENTAL ☐ EMPLOYEE OWNED	DEPT. VEHICLE NO. (Optional)
DESCRIBE DAMAGES TO STATE VEHICLE		ESTIMATED REPAIR COST	IF DEPARTMENT OWNED OR RENTAL, ENTER OWNER'S NAME	

ACCIDENT DETAILS *(See Reverse for Diagram and Description)*

ACCIDENT LOCATION *(Address/Area)*	ROAD CONDITIONS
	WEATHER CONDITIONS
(City/State)	TRAFFIC CONDITIONS
(County)	HOW FAST WERE YOU DRIVING? / EST. SPEED OF OTHER CAR

POLICE REPORT MADE ☐ YES ☐ NO

NAME AND ADDRESS OF INVESTIGATING AGENCY

AGENCY ☐ CHP ☐ OTHER

OTHER VEHICLE

DRIVER'S NAME	AGE / DOB		VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL	NO. OF PASSENGERS
DRIVER'S LICENSE NO.	HOME TELEPHONE	WORK TELEPHONE	REGISTERED OWNER		
DRIVER'S ADDRESS *(Street, City, State, Zip Code)*			OWNER'S ADDRESS	HOME TELEPHONE / WORK TELEPHONE	
BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY			NAME AND ADDRESS OF OTHER PARTY'S INSURANCE		

INJURED

NAME	AGE	ADDRESS	HOSPITAL
NAME	AGE	ADDRESS	HOSPITAL

WITNESS

NAME	TELEPHONE	ADDRESS
NAME	TELEPHONE	ADDRESS

VEHICLE PASSENGERS

	NAME	ADDRESS
STATE	NAME	ADDRESS
	NAME	ADDRESS
OTHER	NAME	ADDRESS

(CONTINUE ON REVERSE)

STATE OF CALIFORNIA - DGS ORIM

VEHICLE ACCIDENT REPORT

STD. 270 (REV. 2/2002c) (REVERSE)

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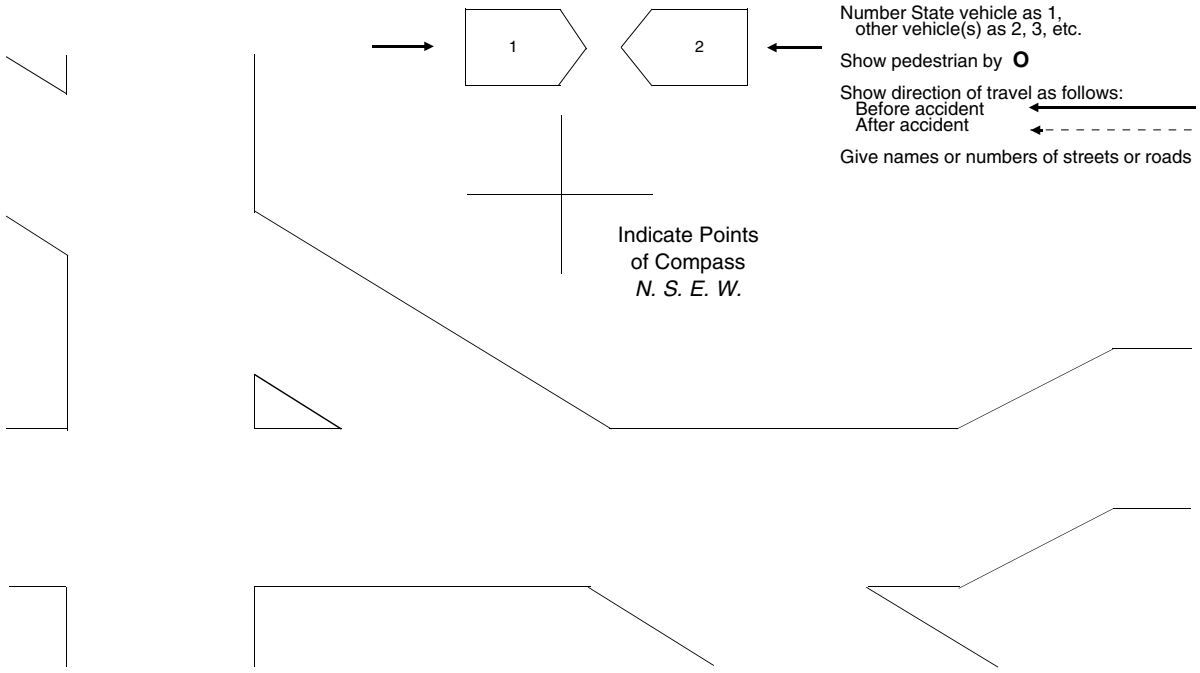
ACCIDENT DETAILS - DESCRIPTION

FULLY STATE HOW ACCIDENT OCCURRED *(Give details, attach additional sheets if necessary)*

ACCIDENT DETAILS - DIAGRAM



Number State vehicle as 1, other vehicle(s) as 2, 3, etc.

Show pedestrian by **O**

Show direction of travel as follows:
Before accident
After accident

Give names or numbers of streets or roads

ADDITIONAL VEHICLE/PASSENGER(S)

VEHICLE

DRIVER'S NAME	AGE/DOB	VEHICLE LICENSE NUMBER	VEHICLE YEAR, MAKE, MODEL

DRIVER'S LICENSE NO.	HOME TELEPHONE	WORK TELEPHONE	REGISTERED OWNER

ADDRESS *(Street, City, State, Zip Code)*	ADDRESS *(Street, City, State, Zip Code)*	HOME TELEPHONE
BRIEFLY DESCRIBE DAMAGES TO OTHER VEHICLE OR PROPERTY		WORK TELEPHONE
	NAME AND ADDRESS OF OTHER PARTY'S INSURANCE CARRIER	

INJURED

NAME	AGE	ADDRESS	HOSPITAL
NAME	AGE	ADDRESS	HOSPITAL

PASSENGER

NAME	ADDRESS
NAME	ADDRESS

The answers in this report contain a true and full account of the accident, and the vehicle was being operated on official business of the state at the time of the accident. (The reviewing officer is to explain any exception.) ***Attach extra pages as necessary.***

Employee Signature and Date	*Reviewing Officer Signature (Supervisor or Safety Coordinator)*	*Type Name and Title of Reviewing Officer* *Telephone Number of Reviewing Officer*