CONFIDENTIAL: CLAIM INVESTIGATIVE MATERIALS

COMMONWEALTH OF VIRGINIA

Vehicle Pool Number

Automobile Incident Report

Agency Driver: Complete this form and email it to DRMClaims@trs.virginia.gov or send by fax: 804-371-2442

If available, include a copy of the police report

Do not discuss accident with anyone except Commonwealth of Virginia representative and police

Your Agency	**Name of agency and institution / division**							**State vehicle's license plate number**
	Commonwealth of Virginia - Virginia Department of Forestry							
	Agency address Street / P.O. Box			City	State	Zip code		**Phone number**
	900 Natural Resources Drive - Suite 800 Charlottesville VA 22903							434-220-9096

Time and Place of Accident	**Date of accident**	**Hour**	**Location**	**Street or highway**	**City /County**	**State**
		A.M. / P.M.				

BY THE TERMS OF THE AGENCY'S COVERAGE THE COMMONWEALTH MUST BE GIVEN A REASONABLE OPPORTUNITY TO EXAMINE YOUR AUTO BEFORE REPAIRS ARE MADE.

Your Auto	**Make of auto**	**Year**	**Body type**	**Vehicle Identification Number**		**Police called?**	Y	N	
						Name of police department			
	Name of owner or leasing company			**Address**	Street	City	State	Zip Code	
	Name of driver			**Address**	Street	City	State	Zip Code	
	Driver's date of birth		**Driver's license number**		**Was license in effect at time of accident?**				
	Purpose of trip		**Who gave permission?**		**Where were you going when the accident happened?**				
					Where were you coming from when the accident happened?				
	Where is the vehicle now?			**Estimated cost of repairs**					

Other Auto Involved	**Make of other auto**	**Year**	**Body type**	**Estimated cost of repairs**				
	Describe damage to other auto							
	Name of other driver		**Address**	Street	City	State	Zip Code	
	Name of other auto's owner		**Address**	Street	City	State	Zip Code	
	Is other auto insured?	**Name of other auto's insurance company**						

Passengers	**Names of passengers in your auto**	**Addresses**	Street	City	State	Zip Code
	Names of passengers in other auto	**Addresses**	Street	City	State	Zip Code

Injuries (No matter how minor)	**Names of persons injured**	**Addresses**		Injuries	Age
	In which auto were the injured riding?				
	Name of doctor / hospital	**Addresses**	Street	City	State	Zip Code

NEITHER SUBMITTED NOR ACCEPTED AS NOTICE IN SATISFACTION OF ANY FILING REQUIREMENTS

Property Damage Other than Auto

Name of owner	Address Street	City	State	Zip Code

Kind of property	

Estimated cost of repair	Where may property be seen?

Witnesses

Names / phone numbers	Addresses Street	City	State	Zip Code

Description of Accident

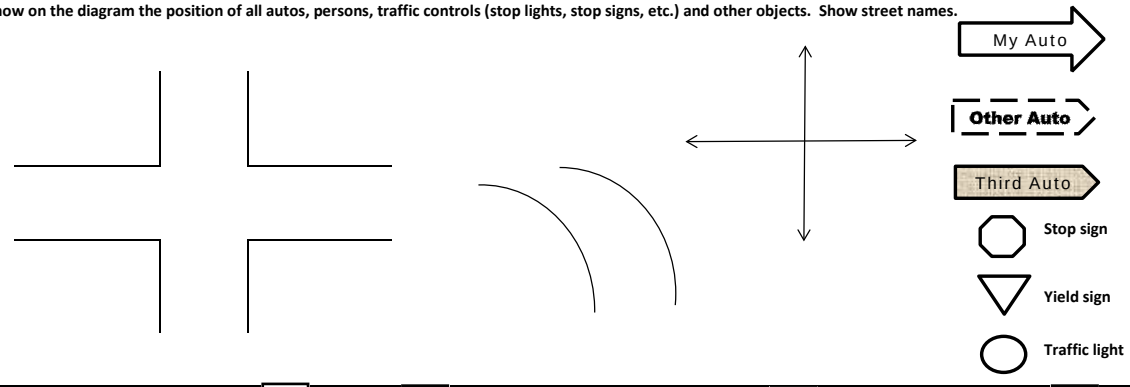
On what street were you driving?	Direction	Speed	Street or road other auto was driving on	Direction	Speed

Were your lights on?			Were the other auto's lights on?			Traffic controls in place?	For whom?	Speed Limit
Y	Bright	Dim	Y	Bright	Dim			
N			N					

Did either driver give signal of any kind?		If intersection who entered first?	Who had right of way?
Y	If yes, who?		
N			

Describe how the accident happened. Include any special details of the collision. Attach additional sheets if needed.

Show on the diagram the position of all autos, persons, traffic controls (stop lights, stop signs, etc.) and other objects. Show street names.



Your Auto's Glass Breakage

Type of glass:			Type of break			
Tinted		Safety	Shattered	Cracked	Chipped or pitted	
Clear		Plate		Bull's eye	Half moon	

Location of breakage	Vent	Rear	Door	Other (describe)
Windshield				

Windshield damage: check "Type of glass" and "Type of break", above, and mark location on diagram

Do you think a claim will be made against you?	By whom?
Y / N / Uncertain	

Who is your supervisor?	
Your supervisor's phone number	
What is your title / position?	Your signature
	Date
Your phone number	Your email address

NOTE: When submitting this form electronically, your initials below will serve as your electronic signature.

Reported to (Name)	Initials	Reported by (Name)	Initials	Date reported