Texas Council
Risk Management Fund

Complete and Return to OSCTexas@yorkrsg.com

ACCIDENT REPORT FORM

Complete both sides of this form to gather information at the accident scene that is required to document this accident. Make sure you document the other driver's information as well as list any passengers of the vehicles and witnesses to the accident. Submit the completed form to the individual in your center who is responsible for monitoring and reporting accidents to the Fund. If you have any questions or need assistance, contact the Fund during regular business hours (8AM to 5PM, Monday through Friday) at 1-800-580-6467.

1. MEMBER INFORMATION:

Member Name: ____________________ **Contact Person:** ____________________

Contact Phone Number: ____________________

(Keep this form in your glove box and use it in case you have an accident.)

2. ACCIDENT INFORMATION:

DATE OF LOSS (MM/DD/YY:)	TIME OF LOSS: AM PM	LOCATION OF ACCIDENT (Include City and State):
POLICE CONTACTED: Yes No	OFFICER'S NAME:	POLICE REPORT NUMBER:

DESCRIPTION OF ACCIDENT: Were you ticketed? Yes No If yes, what was the ticket for? ____________________

3. DESCRIBE WHAT HAPPENED:

4. YOUR VEHICLE INFORMATION:

YEAR:	MAKE:	MODEL:	VEHICLE IDENTIFICATION NUMBER (VIN):	LICENSE PLATE #:

DRIVER'S NAME:	DATE OF BIRTH (MM/DD/YY):	DRIVER'S LICENSE NUMBER & STATE:
DRIVER'S HOME ADDRESS:	DRIVER'S WORK PHONE:	DATE DRIVER HIRED:
	DRIVER'S HOME PHONE:	DATE LICENSE EXPIRES: (List restrictions in description of accident above.)

INJURIES: Yes No If yes, continue on back.	ADDRESS WHERE VEHICLE CAN BE INSPECTED:

5. OTHER PARTY'S PROPERTY DAMAGE:

DESCRIPTION (If auto, indicate Year, Make, Model and VIN)	LICENSE PLATE #:	OTHER VEHICLE/ PROPERTY INSURED? Yes No	COMPANY/AGENCY NAME:

OWNER'S NAME:	DATE OF BIRTH (MM/DD/YY):	DRIVER'S LICENSE NUMBER & STATE:

OWNER'S ADDRESS:	WORK PHONE:	HOME PHONE:

OTHER DRIVER'S NAME: (CHECK IF SAME AS OWNER) D	DRIVER'S LICENSE NUMBER & STATE:

OTHER DRIVER'S ADDRESS:	WORK PHONE:	HOME PHONE:

INJURIES: Yes No If yes, continue on back.	ADDRESS WHERE VEHICLE CAN BE INSPECTED:

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6.

INJURED INDIVIDUALS:				
NAMES AND ADDRESS:	PHONE(S):	AGE:	LOCATION:	EXTENT OF INJURY:
	Home: Work:		Pedestrian Insured Vehicle Other Vehicle	Describe: Initial Treatment:
	Home: Work:		Pedestrian Insured Vehicle Other Vehicle	Describe: Initial Treatment:
	Home: Work:		Pedestrian Insured Vehicle Other Vehicle	Describe: Initial Treatment:

7.

WITNESSES OR PASSENGERS:			
NAMES AND ADDRESS:	PHONE(S):	LOCATION:	DETAILS:
	Home: Work:	Pedestrian Insured Vehicle Other Vehicle	
	Home: Work:	Pedestrian Insured Vehicle Other Vehicle	

8.

Weather:	Surface:	Type:	Involved With:
Clear	Dry	Head On	Moving Vehicle
Cloudy	Wet	Side Swipe	Parked Vehicle
Rain/Snow	Snow/Ice	Rear End	Pedestrian
Fog		Side Impact	Bike/Cycle
			Animal
			Fixed Object

Completed by:______________________________ Date: ______________

Toll-Free Number for Automobile Claims
1-800-580-6467

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