SCHOOLS INSURANCE AUTHORITY

(Effective as 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

7/15SIA1.0