

**AUTO COLLISION INFORMATION FORM  
TEXAS TECH UNIVERSITY SYSTEM**

If you have a collision, use this form to record the facts about the collision, including names and address of all parties involved, and any witnesses to the collision. Give the completed form to your Department head. The Department head will send the form to

**Office of Risk Management PO Box 42003 (MS 2003) Lubbock, Texas 79409**

|  |                             |  |  |
|--|-----------------------------|--|--|
| Date of collision and time                               | AM <input type="checkbox"/> | PM <input type="checkbox"/>                                      | Location of Collision (Include City & State) |
| Description of Collision (use reverse side if necessary) |                             |  |  |
| Authority Contacted and Report #                         |                             | Any violations/citations as a result of the collision (describe) |  |

**PROPERTY DAMAGED (NOT YOUR VEHICLE)**

|  |                 |                                    |  |
|--|-----------------|------------------------------------|--|
| Describe Property<br>(If auto, year, make, model, plate #)                         |                 | Insurance Company                  |  |
| Owner's Name & Address   |                 | Residence Phone<br>(A/C, No. Ext): |  |
|  |                 | Business Phone<br>(A/C, No. Ext):  |  |
| Other Driver's Name & Address<br><input type="checkbox"/> (Check if same as owner) |                 | Residence Phone<br>(A/C, No. Ext): |  |
|  |                 | Business Phone<br>(A/C, No. Ext):  |  |
| Driver's License Number  | Describe Damage | Where can damage be seen?          |  |
| Insurance Company Name   | Policy Number   | Agent's Name and Number            |  |

**INJURED PARTIES**

| Name & Address  | Phone (A/C, No) | Age | Describe Injury |
|---|-----------------|-----|-----------------|
| Injured was: <input type="checkbox"/> Pedestrian <input type="checkbox"/> In your car <input type="checkbox"/> In other car |                 |     |                 |
| Injured was: <input type="checkbox"/> Pedestrian <input type="checkbox"/> In your car <input type="checkbox"/> In other car |                 |     |                 |

**WITNESSES OR PASSENGERS**

| Name & Address | Phone (A/C, No.) | Ins Veh | Oth Veh | Statement Attached? |
|----------------|------------------|---------|---------|---------------------|
|                |                  |         |         |                     |
|                |                  |         |         |                     |

**YOUR INSURED VEHICLE**

|   |               |                    |   |                |  |
|---|---------------|--------------------|---|----------------|--|
| Year  | Make          | Model              | VIN   | License Number |  |
| Department Name                                 |               |                    | Department Phone  |                |  |
| Supervisor to whom you reported:                |               |                    | (A/C, No)   |                |  |
| Department Head Name                            |               |                    |   |                |  |
| Driver's Name & Address                         |               |                    | Residence Phone<br>(A/C, No)<br>Business Phone<br>(A/C, No. Ext): |                |  |
| Relation to Insured<br>(Employee, family, etc.) | Date of Birth | Driver's License # | State   | Purpose of Use | Used with Permission<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe Damage                                 |               |                    | <u>Where</u> can Vehicle be seen?                                 |                | <u>When</u> can Vehicle be seen?   |

**In addition to this form please provide a copy of the police report and OP 80.08 attachments B & C. In the event of collision always contact the appropriate law enforcement agency and ask that they prepare an accident report.**