

**May be EXEMPT RECORD**  
(Contact Risk Management Division)

**DRIVER RESPONSIBILITY:** Complete this form immediately after an accident and/or damage has occurred and submit to UND Transportation @ [UND.transportation@UND.edu](mailto:UND.transportation@UND.edu). Please call UND Transportation with questions at 701.777.4122

<b>AGENCY</b>	Agency Name		Department		
	Address	City	State	Zip Code	Telephone Number
<b>SPECIFICS</b>	Date of Accident	Day of Week	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Type
<b>LOCATION</b>	Location Description (i.e. Highway Number, Posted Speed Limit, Location from Nearest City, City, Street, and Intersection)				

<b>STATE VEHICLE</b>  or UND leased or rented vehicle  <b>No. 1</b>	<b>VEHICLE</b>	Year	Make	Model	Unit Number	Odometer Reading
	Driver's Name			Driver's License Number		Citation Issued <input type="checkbox"/> Yes <input type="checkbox"/> No
	Work Telephone Number			Home Telephone Number		
	Home Address			City	State	ZIP Code
	Driver Injured <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Injury				Worker's Compensation Claim Filed <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Estimated Speed		Direction Traveling		Vehicle Owner	
	Damage (List Parts)					
	Passengers	<input type="checkbox"/> None <input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed	Telephone Numbers Work Work		Telephone Numbers Home Home	

<b>OTHER VEHICLE</b>  <b>No. 2</b>	<b>VEHICLE</b>	Year	Make	Model	License Plate	State
	Driver's's Name			Driver's License Number		Citation Issued <input type="checkbox"/> Yes <input type="checkbox"/> No
	Work Telephone Number			Home Telephone Number		
	Home Address			City	State	ZIP Code
	Direction Traveling	Driver Injured <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Injury				
	Damage (List Parts)					
	Passengers	<input type="checkbox"/> None <input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed	Telephone Numbers Work Work		Telephone Numbers Home Home	

OWNER'S	Insurance Company		Policy Number			
	Address		Telephone Number			
DRIVER'S	Insurance Company		Policy Number			
	Address		Telephone Number			
WITNESS	Name		Address	City	State	ZIP Code
	Location To Accident		Work Telephone Number	Home Telephone Number		
DAMAGE TO OTHER PROPERTY	What		Owner/Name			
	Work Telephone Number	Home Telephone Number	Address	City	State	ZIP Code
OTHERS INJURED/ KILLED	Name			Work Telephone Number	Home Telephone Number	
	Address		City	State	ZIP Code	
	Nature and Extent of Injury					

CONDITIONS	WEATHER	<input type="checkbox"/> Clear	<input type="checkbox"/> Raining	<input type="checkbox"/> Snowing	<input type="checkbox"/> Sleet	<input type="checkbox"/> Foggy	<input type="checkbox"/> Other _____
	ROADWAY	<input type="checkbox"/> Dry	<input type="checkbox"/> Icy	<input type="checkbox"/> Slippery	<input type="checkbox"/> Under Repair	<input type="checkbox"/> Other _____	
	Did Vehicle Have Any Defects? _____						
	Were Seat Belts in Use? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	What Lights Were On? _____						

REPORT	Accident Reported to Law Enforcement <input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle Dispatch Office or DOT Repair Location
	Law Enforcement Agency Name	Law Enforcement Telephone Number

Explain How Accident Occurred and Purpose of Trip

Diagram: Please clearly mark the state vehicle as 1 and the other vehicle as 2. Please attach or submit to UND Transportation:

Individual Preparing Report (Name of State Employee)	Department	Telephone Number	Date
Supervisor Signature	Supervisor printed name	Telephone Number	Date