

VEHICLE ACCIDENT REPORT

For any school owned vehicle. Examples include:

- Bus
- Superintendent cars
- Pool cars
- Maintenance vehicles
- Contractor bus

A copy of the Vehicle Accident Report form is on the following page.



NEW MEXICO
PUBLIC SCHOOLS INSURANCE AUTHORITY
Cannon Cochran Management Services, Inc.
Claims Administrator
P.O. Box 30870
Albuquerque, New Mexico 87190-0870
800-635-0679 505-837-8700
505-888-6901 Fax



Vehicle Accident Report

(For bodily injury or damage to another's property or for damage to your vehicle)

District Name		Address		City	State	Zip	Phone
School/Dept. Name		Address		City	State	Zip	Phone
Driver's Name		Address		City	State	Zip	Phone
Date of Birth		Social Security No.		Driver's License No.			
Vehicle							
Make	Year	Model	Serial #	License #	Where Vehicle May be Seen		
Trailer	Year	Model	Area of Damage	Used for Business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated Cost to Repair \$		
Accident							
Date of Loss	Time of Loss	Location (Street/Highway)			City	State	
Were Police Called to Scene? <input type="checkbox"/> Yes <input type="checkbox"/> No		Police Dept. Called	Driver	Arrested?	Ticketed?	Violation?	
Name of Officer		Station Address					
Claimant 1							
Owner of Other Vehicle		Age	Address	City	State	Zip	Phone
Driver, if other than above		Age	Address	City	State	Zip	Phone
Make	Year	Model	License #	Area of Damage	Where Vehicle May Be Seen	Estimate of Damage \$	
Claimant 2							
Owner of Other Vehicle		Age	Address	City	State	Zip	Phone
Driver, if other than above		Age	Address	City	State	Zip	Phone
Make	Year	Model	License #	Area of Damage	Where Vehicle May Be Seen	Estimate of Damage \$	
Property Damage – Other Than Auto (ie, Fence, Canopy)							
Owner of the Property		Address		City	State	Zip	Phone
Describe Damaged Property			Location of Property			Extent of Damage	
Witness Information							
Name		Address		City	State	Zip	Phone
Name		Address		City	State	Zip	Phone

Vehicle Accident Report

Page 2

Name	Address	City	State	Zip	Phone
Occupation	Age	Where Taken Following Accident			
Pedestrian <input type="checkbox"/>	Fatality <input type="checkbox"/>	No Visible Injury – Some Pain <input type="checkbox"/>			
In Your Vehicle <input type="checkbox"/>	Bleeding/Wound <input type="checkbox"/>	Other <input type="checkbox"/>			
In Claimant <input type="checkbox"/>	Unconscious <input type="checkbox"/>				

Name	Address	City	State	Zip	Phone
Occupation	Age	Where Taken Following Accident			
Pedestrian <input type="checkbox"/>	Fatality <input type="checkbox"/>	No Visible Injury – Some Pain <input type="checkbox"/>			
In Your Vehicle <input type="checkbox"/>	Bleeding/Wound <input type="checkbox"/>	Other <input type="checkbox"/>			
In Claimant <input type="checkbox"/>	Unconscious <input type="checkbox"/>				

Vehicle

Additional Remarks

Describe Accident Accident Resulted In: ☐ Bodily Injury ☐ Prop. Damage ☐ Vehicles ☐ Pedestrian

Accident Diagram

Note: Indicate North By Arrow

What Street Were You On?	Claimant 1	Claimant 2
What Direction Were You Traveling?	Claimant 1	Claimant 2

Weather Conditions Dry <input type="checkbox"/> Wet <input type="checkbox"/> Icy <input type="checkbox"/> Foggy <input type="checkbox"/> Snowy <input type="checkbox"/>	Traffic Conditions Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/>
Speed Limit	Were You Familiar With The Area? Traffic Controls

This Section Must Be Completed By Your Supervisor

1. Do you think a claim will be made against you? Yes ☐ No ☐
2. In my opinion, we are at fault for this accident? Yes ☐ No ☐

IMPORTANT: Has this accident been reported to a CCMSI adjuster? Yes ☐ No ☐

If reported, name of adjuster _____

Signature/Title _____ Date _____