CALIFORNIA STATE UNIVERSITY SACRAMENTO
Risk Management Services

Vehicle Accidents
State Driver Reporting Procedures

Sacramento State drivers must report ALL motor vehicle accidents in CSUS-owned vehicles, as well as those occurring in personal or rental vehicles while being driven on official State business by the following procedures:

1. Say nothing regarding the accident, except to the police, other state officers or employees, or an identified representative of the State's contract adjuster.
2. Call the police 916-278-6900 or 911. If the police request a copy of your insurance, and you are operating a state-owned vehicle, refer them to **CVC 16021**, state ownership of the vehicle establishes financial responsibility.
3. If you are driving a University/State-owned vehicle, complete the "Accident Identification Form" (STD 269) before leaving the scene of the accident.
4. All drivers must complete a "Vehicle Accident Report" (STD 270)
5. All drivers must complete the "Accident or Incident Report" within 24 hours.
6. The supervisor shall complete a "State Driver Accident Review" form (STD 274), and send it to Risk Management Services within five (5) days.

Send all paperwork to Risk Management Services

6000 J Street, River Front Center 220, Sacramento, CA 95819
Phone: 916-278-7233 / 8-6456 / 8-6119
Fax: 916-278-4359 fax
Intracampus Mail Zip 6145

STATE OF CALIFORNIA

REPORTING OF AUTOMOBILE ACCIDENTS

The state administers a vehicle liability self-insurance program against loss for personal injury and property damage to others. The program protects any officer or employee of the state when operating a vehicle on official state business.

All vehicle accident reports (STD 270) must be received by the Office of Risk and Insurance Management (ORIM) within 2 business days after the accident. The report must be completed by the driver and reviewed and approved by their supervisor. The vehicle accident report, along with any additional information related to the accident should be emailed to ORIM at claims@dgs.ca.gov

DO NOT DISCUSS ACCIDENT WITH ANYONE EXCEPT:

1. Investigating Traffic Officers
2. Your Supervisors
3. Authorized State Officers
4. Office of Risk and Insurance Management Claims Analysts

COMPLETE ENTRIES ON ACCIDENT INDENTIFICATION CARD – DETACH AND GIVE TO OTHER DRIVER

N

Indicate Points of Direction

NAME STREETS OR ROADS - SHOW DIRECTION AND POSITION OF ALL VEHICLES IN ACCIDENT.

STATE VEHICLE A

OTHER VEHICLE B

DIAGRAM OF ACCIDENT

ACCIDENT DETAILS

TIME AM PM | DATE | CITY | COUNTY

ACCIDENT LOCATION (Address, Intersection, Etc.) | ROAD CONDITIONS | WEATHER CONDITIONS

INVESTIGATED BY | **REPORT NUMBER**

☐ POLICE DEPT. NAME AND ADDRESS

☐ SHERIFF

☐ CHP

☐ OTHER

OCCUPANTS OF OTHER VEHICLE

NAME ADDRESS PHONE

NAME ADDRESS PHONE

NAME ADDRESS PHONE

OCCUPANTS OF STATE VEHICLE

NAME ADDRESS PHONE

NAME ADDRESS PHONE

STATE OF CALIFORNIA - DGS OFFICE OF RISK AND INSURANCE MANAGEMENT

ACCIDENT IDENTIFICATION

STD. 269 (Rev. 10/2019)

IMPORTANT

Complete entries below, detach this card and give to other driver who may need information for financial responsibility form.

STATE DRIVER FULL NAME

STATE DRIVER WORK TELEPHONE NUMBER

STATE DRIVER LICENSE NUMBER

DEPARTMENT EMPLOYED BY

DATE OF ACCIDENT

ACCIDENT LOCATION

YEAR / MAKE / MODEL OF STATE VEHICLE

LICENSE NUMBER OF STATE VEHICLE

ANY INQUIRY REGARDING ACCIDENT MAY BE ADDRESSED TO:

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK AND INSURANCE MANAGEMENT
707 THIRD STREET, FIRST FLOOR – SUITE 1-150
WEST SACRAMENTO, CA 95605 **(916) 376-5300**
Email: claims@dgs.ca.gov **1-800-900-3634 Toll Free**

(reverse)

should be filled out, detached and given to other driver.

IMPORTANT

ASK NAMES AND ADDRESSES OF **WITNESSES FIRST**

1 NAME | ADDRESS | PHONE

2 NAME | ADDRESS | PHONE

3 NAME | ADDRESS | PHONE

INJURED PERSONS

NAME | DOB

ADDRESS | PHONE

HOSPITAL TAKEN TO

NAME | DOB

ADDRESS | PHONE

HOSPITAL TAKEN TO

OTHER VEHICLES

VEHICLE LICENSE NO. | YEAR / MAKE / MODEL

REGISTERED OWNER

ADDRESS | CITY

DRIVER'S NAME

ADDRESS | CITY

DRIVER'S LICENSE NO.

(OVER)

EVIDENCE OF FINANCIAL RESPONSIBILITY

This vehicle is owned or leased by the State of California, a public entity, and operated by employees or agents of the State. California Vehicle Code Sections 16000, 16020, 16021 et seq. state that ownership or lease of a vehicle by a public entity establishes evidence of financial responsibility.

REPORTING OF CLAIMS

All vehicle accident reports (STD 270) must be received by ORIM within 2 business days after the accident. The report must be completed by the driver and reviewed and approved by their supervisor. The vehicle accident report, along with any additional information related to the accident should be emailed to ORIM at claims@dgs.ca.gov

OFFICE OF RISK AND INSURANCE MANAGEMENT

(916) 376-5300

(800) 900-3634 TOLL FREE

CLAIMS@DGS.CA.GOV

STATE OF CALIFORNIA

VEHICLE ACCIDENT REPORT

STD 270 (Rev. 02/2021)

Submit by Email | Reset Form

****CONFIDENTIAL INFORMATION****

DO NOT RELEASE TO OTHER PARTIES WITHOUT CONSENT OF THE OFFICE OF RISK AND INSURANCE MANAGEMENT.

This report must be received by ORIM within 2 business days after accident.

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK AND INSURANCE MANAGEMENT
916.376.5300
claims@dgs.ca.gov

STATE DRIVER

NAME			EMPLOYING DEPARTMENT
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	JOB TITLE
STATE DRIVER'S EMAIL			OFFICE ADDRESS *(Street, City, State, Zip Code)*
WAS VEHICLE BEING USED ON OFFICIAL STATE BUSINESS? ☐ YES ☐ NO *(If NO, attach explanation)*			SUPERVISOR NAME
			SUPERVISOR EMAIL / SUPERVISOR PHONE

STATE VEHICLE

VEHICLE LICENSE NUMBER	VEHICLE YEAR	MAKE	MODEL	VEHICLE EQUIPMENT NUMBER
VEHICLE OWNER: Indicate Dept. Owned*, Rental*, DGS Pool, or Employee Owned				* If Dept. Owned or Rental, Enter Owner's Name

DESCRIBE DAMAGES TO STATE VEHICLE AND PROVIDE A BRIEF DESCRIPTION OF THE INCIDENT

ACCIDENT DETAILS

ACCIDENT LOCATION *(Address/Area)*			ACCIDENT DATE / ACCIDENT TIME	POLICE REPORT MADE? YES: ☐ NO: ☐
CITY	STATE	ZIP CODE	INVESTIGATING AGENCY NAME AND ADDRESS	
COUNTY				

OTHER VEHICLE

DRIVER'S NAME			VEHICLE LICENSE NO.	VEHICLE YEAR	MAKE	MODEL
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	REGISTERED OWNER		OWNER PHONE	NO. OF PASSENGERS
DRIVER'S ADDRESS			OWNER ADDRESS *(Street, City, State, Zip Code)*			
CITY	STATE	ZIP	NAME AND POLICY NUMBER OTHER PARTY'S INSURANCE			

BRIEFLY DESCRIBE DAMAGE TO OTHER VEHICLE/PROPERTY

STATE OF CALIFORNIA

VEHICLE ACCIDENT REPORT

STD 270 (Rev. 02/2021)

Submit by Email | Reset Form

****CONFIDENTIAL INFORMATION****

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This report must be received by ORIM within 2 business days after accident.

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK AND INSURANCE MANAGEMENT
916.376.5300
claims@dgs.ca.gov

INJURED

NAME	DATE OF BIRTH	ADDRESS *(Street, City, State, Zip Code)*
NAME	DATE OF BIRTH	ADDRESS *(Street, City, State, Zip Code)*

WITNESS

NAME	PHONE	ADDRESS *(Street, City, State, Zip Code)*
NAME	PHONE	ADDRESS *(Street, City, State, Zip Code)*

ADDITIONAL VEHICLE

DRIVER'S NAME			VEHICLE LICENSE NO.	VEHICLE YEAR	MAKE	MODEL
DRIVER'S LICENSE NUMBER	DATE OF BIRTH	PHONE	REGISTERED OWNER			OWNER PHONE
DRIVER'S ADDRESS *(Street, City, State, Zip Code)*			OWNER ADDRESS *(Street, City, State, Zip Code)*			

NAME AND POLICY NUMBER OTHER PARTY'S INSURANCE

DESCRIBE DAMAGE TO OTHER VEHICLE/PROPERTY

Print Form | Reset Form | Save Form

STATE OF CALIFORNIA
STATE DRIVER ACCIDENT REVIEW
STD. 274 (Rev. 10/2019)

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK OF INSURANCE MANAGEMENT

Supervisor's Review - For Departmental Accident Prevention

PURPOSE: For the supervisor to investigate each accident, report facts and circumstances, confirm that the State vehicle was used on State business, and initiate or recommend action to achieve accident prevention.

HOW: Use sources of information listed on the back of this form. Report all accidents, what property was damaged and who was responsible (SAM 2430/2440).

WHO: The supervisor of the driver must prepare this report. Attach the STD 274 to the completed STD 270. Forward the completed forms to the Office of Risk and Insurance Management and your departments Health and Safety Coordinator/Unit. Keep a copy for your records.

REVIEWING OFFICER: You are responsible for reviewing the forms to ensure they are accurate and complete.

STATE DRIVER'S NAME	EMPLOYING DEPARTMENT	ACCIDENT DATE

HOW DID ACCIDENT OCCUR?

WHAT DRIVING RULES, VEHICLE LAWS OR VIOLATIONS CONTRIBUTED TO THE CAUSE OF THE ACCIDENT?

SUPERVISOR'S ACTION TAKEN, OR RECOMMENDATION FOR SUPERIORS TO PUT INTO EFFECT. (SEE LAST PAGE FOR SUGGESTIONS)

SUPERVISOR NAME (PRINT)	SUPERVISOR TITLE	SUPERVISOR TELEPHONE
SUPERVISOR SIGNATURE	DATE	

REVIEWING OFFICER EVALUATION AND ACTION TAKEN

☐ I Concur With Supervisor ☐ I Do Not Concur With Supervisor

HOW WAS THE DRIVER INFORMED OF YOUR EVALUATION AND FOLLOW-UP ACTION:

☐ Verbal Discussion ☐ Written Memo ☐ Verbal and Written Date: _____

REVIEWER NAME (PRINT)	REVIEWER TITLE	REVIEWER TELEPHONE
REVIEWER SIGNATURE	DATE	

Print Form | Reset Form | Save Form

STATE OF CALIFORNIA
STATE DRIVER ACCIDENT REVIEW
STD. 274 (Rev. 10/2019)

DEPARTMENT OF GENERAL SERVICES
OFFICE OF RISK OF INSURANCE MANAGEMENT

SOURCES OF INFORMATION INVESTIGATED BY SUPERVISOR IN ADDITION TO STD. 270 PREPARED BY DRIVER

DID YOU?

- ☐ Question state driver
- ☐ Go to scene of accident
- ☐ Closely examine seat belts and safety equipment
- ☐ Examine mechanical defects
- ☐ Read police report and citations
- ☐ Review DL-254, abstract of license records - DMV
- ☐ Review driver's file -- Department of Records
- ☐ Ask about any distractions or attention diverters, prior to accident (i.e., cellphone, eating, reaching, talking)
- ☐ Consider, was our driver influenced by fatigue, illness, medicine or alcohol? If checked, explain below

SOME ACTION SUGGESTIONS AND RECOMMENDATIONS (EXPLAIN ON PAGE ONE)

- ☐ Driver habits need to be observed in traffic
- ☐ Our driver was a contributing factor (memo to driver)
- ☐ Further training be provided (when, by whom and type
- ☐ Departmental policy or local rules be modified
- ☐ Driver be disciplined (special action suggested)
- ☐ Ask accident review board to advise supervisor
- ☐ No further personnel action be taken
- ☐ Recommend removal from driving status
- ☐ Discuss cumulative driver record
- ☐ Recommend new or change of traffic flow
- ☐ Change or improve equipment
- ☐ Ask for expert consultation

GIVE DATE OF DEFENSIVE DRIVER TRAINING	DATE
Orientation - department policies and rules	
Classroom defensive driver training	
Behind-the-wheel training	
Special mobile equipment training	

SUPERVISOR - CLASSIFY FOR DEPARTMENTAL REPORTING

TYPE OF VEHICLE ACCIDENT:

COLLISION WITH OTHER VEHICLE

- ☐ 1. Evasive maneuver
- ☐ 2. Lost control
- ☐ 3. Hit other vehicle in rear
- ☐ 4. Hit from rear
- ☐ 5. Proceeding straight
- ☐ 6. Crossed into opposing lanes
- ☐ 7. Changing lanes
- ☐ 8. Making right turn
- ☐ 9. Making left turn
- ☐ 10. Backing
- ☐ 11. Mechanical failure
- ☐ 12. Collision with bicycle

SOLO ACCIDENT

- ☐ 13. Evasive maneuver
- ☐ 14. Lost control
- ☐ 15. Collided with stationary object
- ☐ 16. Backing
- ☐ 17. Runaway vehicle
- ☐ 18. Lost load
- ☐ 19. Mechanical failure
- ☐ 20. Struck or was struck by animal

STRIKING PEDESTRIAN

- ☐ 21. In a crosswalk
- ☐ 22. Not in a crosswalk
- ☐ 23. While backing

MISCELLANEOUS ACCIDENT

- ☐ 24. Explain

WAS ACCIDENT PREVENTABLE BY STATE DRIVER? Yes ☐ No ☐

SACRAMENTO STATE

REPORT OF INCIDENT OR ACCIDENT

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

This form must be submitted within 24 hours of receiving information of an incident to, **Risk Management Services.**

SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)

☐ Faculty ☐ Staff ☐ Student Employee ☐ Student Assistant Department: _____

☐ Student ☐ Auxiliary ☐ Contractor ☐ Visitor ☐ Volunteer ☐ Other _____ Police Report Made ☐ YES ☐ NO

SECTION 2: INCIDENT TYPE

☐ Injury ☐ Illness ☐ Vehicle ☐ Near Miss ☐ Dangerous Condition ☐ Exposure Incident ☐ Other _____

SECTION 3: INVOLVED/INJURED'S INFORMATION

First Name: _____ Last Name: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

SECTION 4: INCIDENT DETAILS

Note: If an accident occurred while driving on university business, you must also complete the Vehicle Accident Report form STD 270.

Date of Incident: _____ Time: AM/PM _____ Location: _____

Multiple persons involved ☐ YES ☐ NO

DESCRIBE THE INCIDENT (STATE ONLY THE FACTS).

What was the person doing just prior to and at the time of the incident? What objects/conditions contributed to the incident?

Name(s) Witnesses: _____

If the incident resulted in an injury or illness, answer the following questions.

a) Describe injury and part of body affected. _____

b) Did the individual receive first aid only? ☐ YES ☐ NO

c) Did the individual receive medical treatment? ☐ YES ☐ NO

d) Was the individual hospitalized? ☐ YES ☐ NO

Name of Clinic: _____ Physician: _____ Phone Number: _____

If this is a Sacramento State employee, what time did the employee begin their shift?: _____ ☐ a.m. ☐ p.m. ☐ N/A

a) Supervisor: _____ Title: _____ Date/Time notified: _____

b) Did the individual immediately return to work? ☐ YES ☐ NO

Preparer's Name and Title (Print)	Phone Number	Date

"SAVE AS" to computer: fax copy to: (916) 278-2641 or email to: rms@csus.edu