

Automobile Accident Report
Cornell College
600 First Street SW, Mount Vernon, IA 52314-1098

ACCIDENT INFORMATION

DATE OF ACCIDENT	TIME : ____ AM ____ : ____ PM	PLACE OF ACCIDENT (STREET OR HIGHWAY, CITY, STATE)
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DETAILED DESCRIPTION OF ACCIDENT

WERE THERE ANY WITNESSES? YES NO

WITNESS NAME	WITNESS ADDRESS
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WITNESS PHONE NO. (CELL, HOME, BUSINESS)	WITNESS EMAIL ADDRESS	BEST TIME AND NUMBER TO CONTACT WITNESS
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WHERE WAS THIS WITNESS AT THE TIME OF ACCIDENT?	RELATIONSHIP OF WITNESS TO ANY PARTIES INVOLVED
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ANY OTHER WITNESSES? YES NO (IF "YES" PROVIDE INFORMATION AS ABOVE ON A SEPARATE PAGE.)

WERE ANY AUTHORITIES CONTACTED? YES NO (IF "YES" COMPLETE THE FOLLOWING)

NAME OF AUTHORITY (Police, Ambulance, Fire, etc.)	AUTHORITY ADDRESS AND PHONE
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REPORT NUMBER (if available)	VIOLATIONS OR CITATIONS ISSUED? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF "YES" DESCRIBE)
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COLLEGE VEHICLE INFORMATION

YEAR, MAKE, MODEL	VEHICLE IDENTIFICATION NO.	PLATE NO.
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STATE	COLOR OF VEHICLE	DOES THE COLLEGE OWN THE VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NOT COLLEGE-OWNED, LIST OWNER OF VEHICLE OR RENTAL COMPANY
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DRIVER'S NAME	DRIVER'S LICENSE NO. & STATE	DRIVER'S ADDRESS	DRIVER'S EMAIL ADDRESS
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DRIVER'S PHONE NO. (CELL, HOME, BUSINESS)	BEST TIME AND NUMBER TO CONTACT DRIVER	HAS DRIVER TAKEN CORNELL'S ALERT DRIVER TRAINING? <input type="checkbox"/> YES <input type="checkbox"/> NO
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WAS THERE DAMAGE TO INSURED VEHICLE? YES NO DESCRIPTION OF DAMAGE (POINT OF IMPACT AND EXTENT OF DAMAGE)

ESTIMATE OF DAMAGE \$

LOCATION OF VEHICLE (NAME, ADDRESS, PHONE NUMBER) IS VEHICLE DRIVABLE? YES NO

INJURIES (IF MORE THAN ONE PERSON, INCLUDE THIS INFORMATION ON EACH ONE ON A SEPARATE PAGE.)

NAME (FIRST, MIDDLE, LAST)	ADDRESS
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HOME PHONE NO.	BUSINESS PHONE NO.	CELL PHONE NO.	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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DESCRIPTION OF INJURY

WAS MEDICAL TREATMENT RECEIVED? YES NO

NAME OF HOSPITAL/CLINIC/DOCTOR	ADDRESS OF HOSPITAL/CLINIC/DOCTOR	PHONE NO.
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TYPE OF TREATMENT	LENGTH OF STAY	SPECIALTY OF DOCTOR	FIRST DAY OF TREATMENT
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IS INJURED REPRESENTED BY AN ATTORNEY? YES NO WAS LAWSUIT SERVED? YES NO (IF "YES" DATE)

NAME OF ATTORNEY	ADDRESS OF ATTORNEY	ATTORNEY PHONE NO.
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EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NO.
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WHERE WAS INJURED PERSON AT TIME OF THE ACCIDENT?

1. INSURED DRIVER 2. GUEST IN INSURED AUTO 3. PEDESTRIAN 4. DRIVER OR OCCUPANT OF OTHER VEHICLE

OTHER VEHICLE INFORMATION (IF MORE THAN ONE VEHICLE, INCLUDE THIS INFORMATION ON EACH ONE ON A SEPARATE PAGE.)

YEAR, MAKE, MODEL	VEHICLE IDENTIFICATION NO.	PLATE NO.	STATE	COLOR OF VEHICLE
OWNER NAME (FIRST, MIDDLE, LAST)	OWNER'S ADDRESS	PHONE NO. (CELL, HOME, AND BUSINESS)		
DRIVER'S NAME (FIRST, MIDDLE, LAST)	DRIVER'S ADDRESS	PHONE NO. (CELL, HOME, AND BUSINESS)		
DRIVER'S LICENSE NO. AND STATE	BEST TIME, PLACE AND NUMBER TO CONTACT DRIVER			
WAS THERE DAMAGE TO OTHER VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	DESCRIPTION OF DAMAGE (POINT OF IMPACT AND EXTENT OF DAMAGE)			
ESTIMATE OF DAMAGE \$				
LOCATION OF VEHICLE (NAME, ADDRESS, PHONE NUMBER)	IS VEHICLE DRIVABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CONTACT FOR FURTHER DETAILS (NAME, ADDRESS, PHONE NUMBER)				

ADDITIONAL COMMENTS (OLD DAMAGE, RENTAL NEEDED, ETC.)

NAME OF OTHER PARTY'S INSURANCE COMPANY	ADDRESS	PHONE NO.
POLICY NO.	CLAIM NO.	AGENT NAME
		AGENT PHONE NO.

PROPERTY DAMAGE INFORMATION (Other than vehicles)

OWNER'S NAME (FIRST, MIDDLE, LAST)	OWNER'S ADDRESS		
HOME PHONE NO.	BUSINESS PHONE NO.	CELL PHONE NO.	EMAIL ADDRESS
DESCRIPTION OF ITEM DAMAGED AND DESCRIBE DAMAGE TO ITEM			ESTIMATE OF DAMAGE

IF OTHER PROPERTY DAMAGE, REPEAT ABOVE SECTION.

ADDITIONAL COMMENTS:

*Please keep this brochure
in your glove compartment*

IN CASE OF A MOTOR VEHICLE ACCIDENT

Here's What to Do

1. Take precautions necessary to protect the accident scene from further accidents.
2. Call the police. If someone is injured, request medical assistance. If fire is involved, request fire department aid.
3. Answer police questions. Give identifying information including insurance coverage to other party involved, but make no comments about assuming responsibility.
4. Complete this AUTOMOBILE ACCIDENT REPORT. You will need this information later for state and insurance reports.
5. As soon as possible, report the accident to the Controller in Cornell Business Services (319-895-4245), but no later than 24 hours after the incident.
6. Notify your Department Head of the incident.