



VEHICLE ACCIDENT REPORTING PROCEDURES

1. Render aid or assistance to the injured (Section 321.263, Code of Iowa).
2. Do not admit fault and do not discuss the accident with anyone except Iowa Department of General Services Risk Management or law enforcement authorities.
3. Notify the nearest law enforcement agency immediately if accident involves a fatality, injury, or property damage.
4. If the accident involves another party, please use the attached Information Exchange sheet.
5. Notify your supervisor.
6. During Normal Working Hours: Immediately notify Iowa Department of General Services Risk Management at 515-281-7703.
7. Complete State of Iowa Vehicle Accident Report (form attached).
8. If the accident results in injury or death of any person, or total property damages to an apparent extent of \$1,000 or more, the accident report required by Section 321.266, Code of Iowa, must be filed within 72 hours after accident. (Forms available from Investigating Officer.)

If you have questions, please call 515-281-7703.

Code Information

Vehicle Type Codes

01 = Passenger Car	09 = Truck Tractor/Semi	17 = Bicycle, etc.
02 = Car & Trailer	10 = Double Bottom Truck	18 = Recreation Veh. (ATV, Snowmobile)
03 = Panel Truck	11 = Tow Truck/Wrecker	19 = Maint./Const. Veh. (Dozer, Graders, Tractors, Etc.)
04 = Pickup Truck	12 = Motor Home	20 = Train
05 = Pickup & Trailer	13 = Bus	21 = Other (Describe)
06 = Pickup Camper	14 = School Bus	22 = Moped
07 = Straight Truck	15 = Farm Veh./Equip.	23 = Multi-Purpose (Sport Utility Van, Minivan)
08 = Truck Tractor	16 = Motorcycle	00 = Unknown

Injury Severity Codes

- 1 = Fatal
- 2 = Major injuries (broken bones, severe cuts, head injuries, etc.)
- 3 = Minor injuries (small cuts, bruises and abrasions)
- 4 = Possible injuries (no visible injury, but individual complaints of pain or discomfort)

State of Iowa -- Department of General Services

VEHICLE ACCIDENT REPORT

Do Not Write In This Box
File No.

Report: This report is to be completed by the driver of the department vehicle.

Distribution: Original to Department of General Services within 72 hours of the accident. One copy to the driver's department headquarters.

NOTICE: Follow "Vehicle Accident Reporting Procedures".

TIME AND LOCATION OF ACCIDENT

Accident Date (Mo/Day/Year)		Day of Week		Time	<input type="text"/>	A.M.	Number of Vehicles
County		State			<input type="text"/>	P.M.	
Road No.	Mile Post	# Miles	<input type="checkbox"/> North <input type="checkbox"/> South	<input type="checkbox"/> West <input type="checkbox"/> East	of (City/Town and State)		

NO. 1 (STATE VEHICLE)

Driver's Name (Last, First, MI)			Work Street Address				
Driver's License No./ State			Work City/ State/ Zip				
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Department			Work Phone	Home Phone	
					()	()	
License Plate No.		VIN		Vehicle Year/ Make/ Model			
State of Registration		Vehicle Type Code		# of Occupants	Leased <input type="checkbox"/> Yes	Vehicle <input type="checkbox"/> No _____ (Company)	
Damage Estimate (\$)	Description of Damage						

NO. 2 (OTHER VEHICLE) If more than two vehicles - use additional forms

Driver's Name (Last, First, MI)			Home Street Address				
Driver's License No./ State			Home Phone		Home City/ State/ Zip		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Work Phone	Vehicle Type Code	Vehicle Year/ Make/ Model/Mileage			# of Occupants
		()					
Owner's Name, Address and Phone			Insurance Company Name/Agent's Name Address and Phone			License Plate No.	
						State of Registration	
Damage Estimate (\$)	Description of Damage						

PROPERTY DAMAGED OTHER THAN VEHICLE (Fence, utility pole, etc.)

Owner's Name, Address and Phone	Property Damage

INJURED PERSONS (Attach additional sheets if necessary)

Name and Address	Describe Injuries	Age	Sex	Injury Code
Vehicle No. 1 (State Vehicle)				
Vehicle No. 2				

UNINJURED PASSENGERS IN YOUR VEHICLE

Name	Address and Phone

WITNESS

Name	Address and Phone

ACCIDENT INFORMATION

A Head On
 B Sideswipe
 C Right Angle
 D Mowing Incident
 E Sanding Incident
 F Rear End
 F1 You hit
 H Glass Only
 I Vandalism
 J Legal Intervention
 K Snow Blower Incident
 F2 You were hit

Did you signal a turn?
 Yes
 No
 If yes, by Signal Light
 Hand Signal
 Which Direction?
 Right
 Left
 Was your seatbelt fastened?
 Yes
 No

Were headlights and taillights burning?
 Yes
 No
 Were safety warning lights burning?
 Yes
 No
 Speed before accident:

ACCIDENT CODES (Description on attached code sheet)

A Location of Accident
B Type of Accident
C Vehicle Action Veh. 1 Veh. 2
D Fixed Object Struck Veh. 1 Veh. 2

E Roadway Geometrics
F Character of Roadway
G Traffic Controls Veh. 1 Veh. 2
H Locality
I Light Conditions

J Weather Conditions
K Type of Trafficway Veh. 1 Veh. 2
L Surface Conditions Veh. 1 Veh. 2
M Surface Type Veh. 1 Veh. 2

N Vision Obscured Veh. 1 Veh. 2
O Apparent Driver Condition Veh. 1 Veh. 2
P Driver/Vehicle Contributing Circumstances Veh. 1 Veh. 2

ACCIDENT DIAGRAM

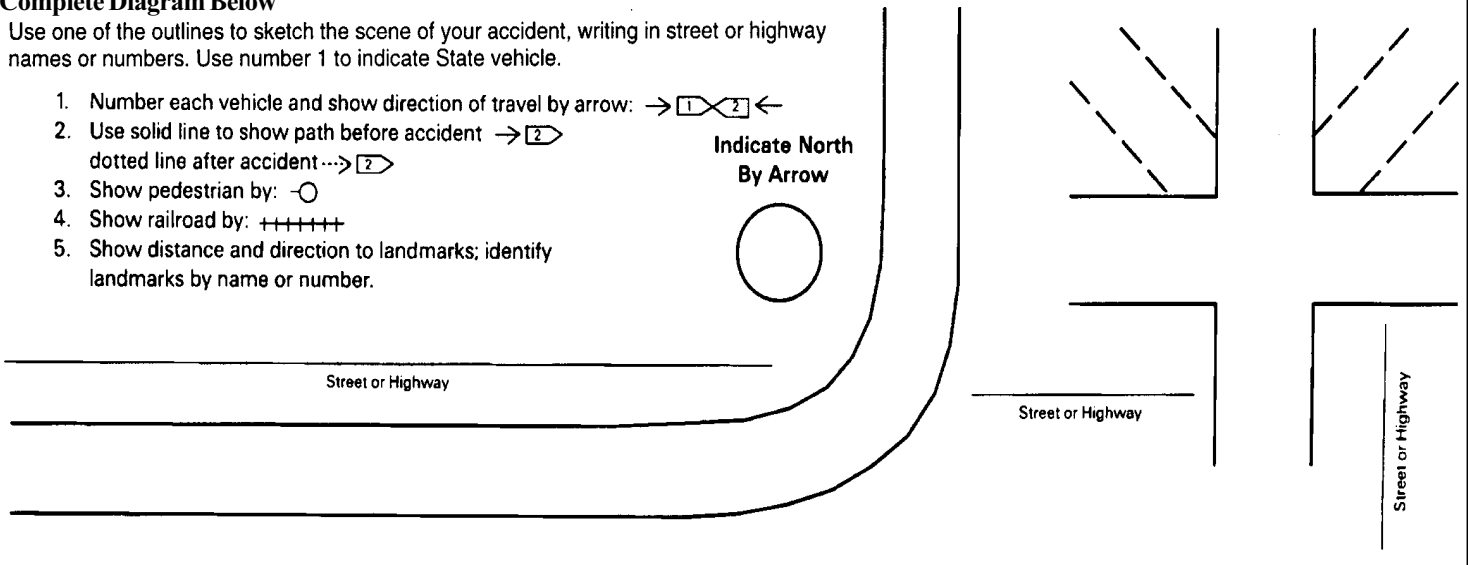
Description of Accident

Complete Diagram Below

Use one of the outlines to sketch the scene of your accident, writing in street or highway names or numbers. Use number 1 to indicate State vehicle.

1. Number each vehicle and show direction of travel by arrow: → 1 ↔ 2 ←
2. Use solid line to show path before accident → 2 dotted line after accident ... → 2
3. Show pedestrian by: -○
4. Show railroad by: ++++++
5. Show distance and direction to landmarks; identify landmarks by name or number.

Indicate North By Arrow



INVESTIGATING OFFICER

Name Badge # Department/Agency/Address

Were charges filed? Yes No If yes, against whom?

Describe Violation (attach copy if you were charged)

SIGNATURES

Signed: _____
Driver

Signed: _____
Driver's Supervisor/Department Head

Social Security Number: _____

State of Iowa -- Department of General Services
ACCIDENT INFORMATION EXCHANGE SHEET

State Employee: Please complete the bottom half of this form and give to the other party. Have the other party complete the top half of this form and give it to you.

Other Vehicle Information

Driver's Name _____

Street Address _____ City, State, Zip _____

Driver License No./State _____ Date of Birth _____

Work Phone No. _____ Home Phone No. _____

Owner's Name _____

Street Address _____ City, State, Zip _____

Name of Insurance Company _____ Policy No. _____

Address of Insurance Company _____ City, State, Zip _____

Type of Vehicle (Pass. Car, Truck, etc.) _____ Mileage _____

Make _____ Year _____ License Plate No. _____

Number of Occupants _____

Names and Addresses of Passengers: _____

Cut Along Dotted Line

State Employee

Name _____ Work Phone _____

Home Address _____ City, State, Zip _____

Driver License No./State _____ Date of Birth _____

Type of Vehicle (Pass. Car, Truck, etc.) _____ Mileage _____

Make/Model _____ Year _____ License Plate No. _____

Owner's Name _____

Street Address _____ City, State, Zip _____

This is to advise the State of Iowa is self-insured.

If you have any questions, please contact:
Iowa Department of General Services
Risk Management
515-281-7703

