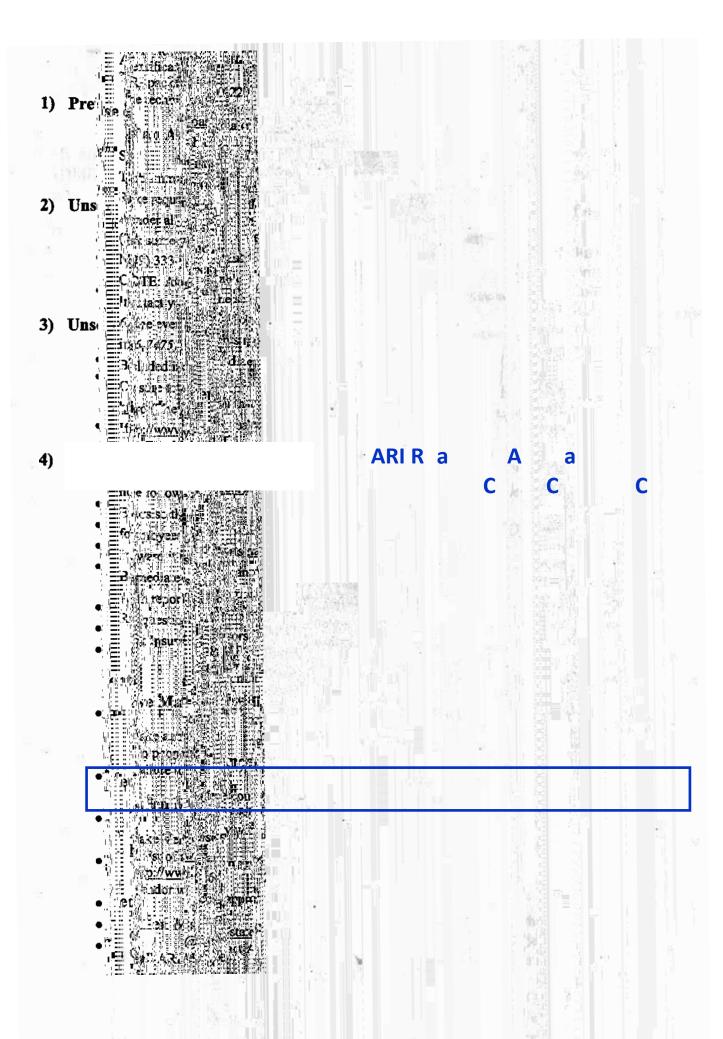
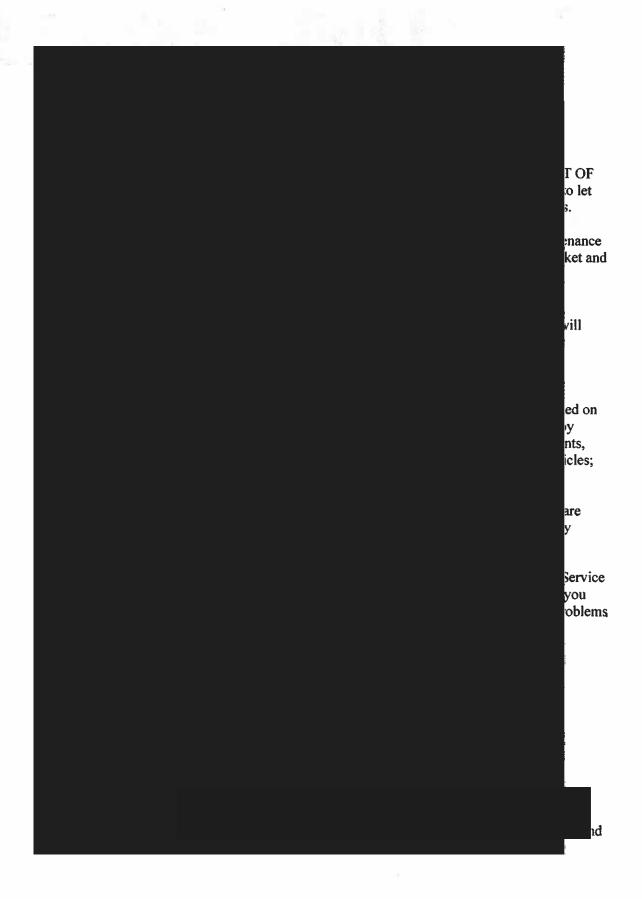


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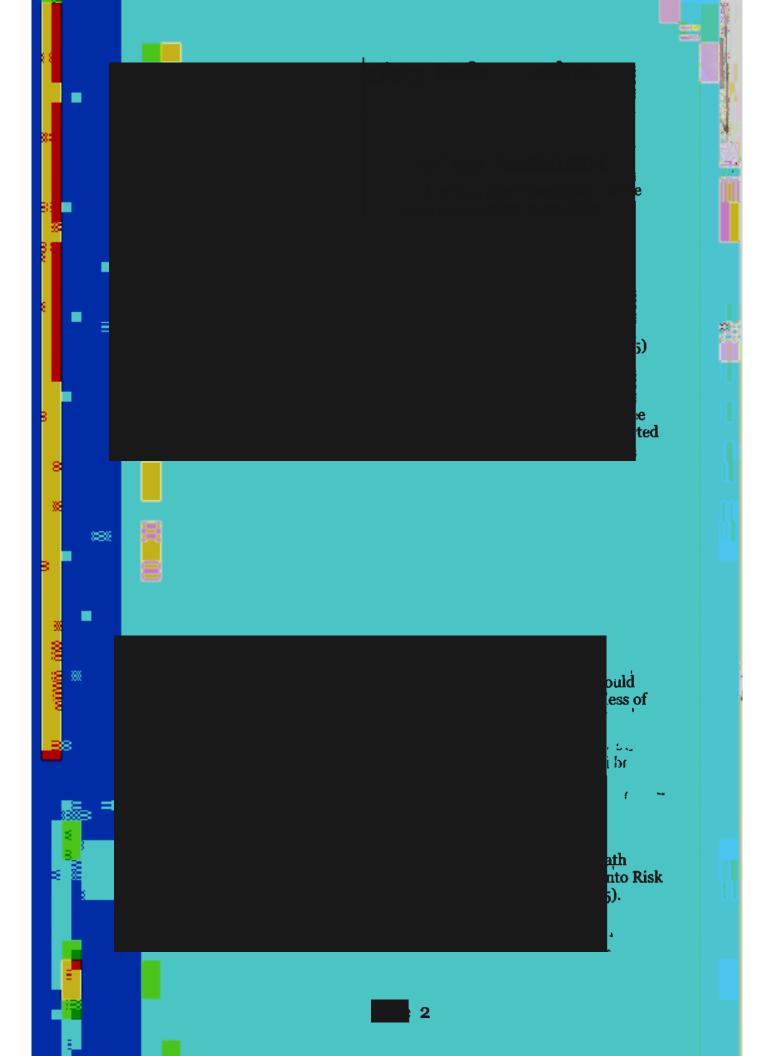
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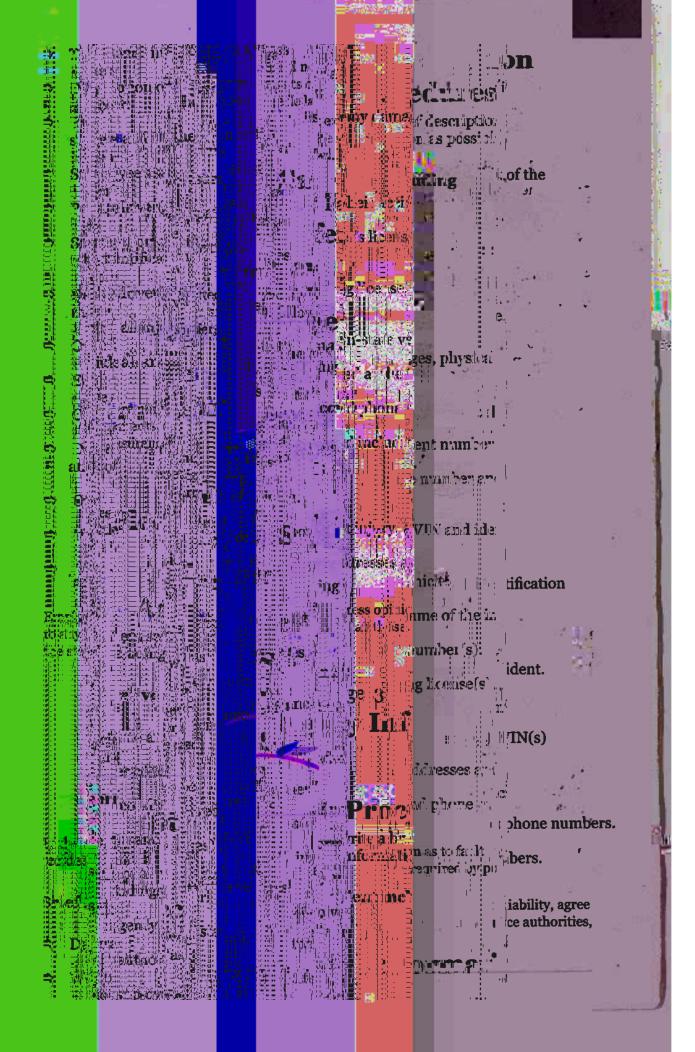




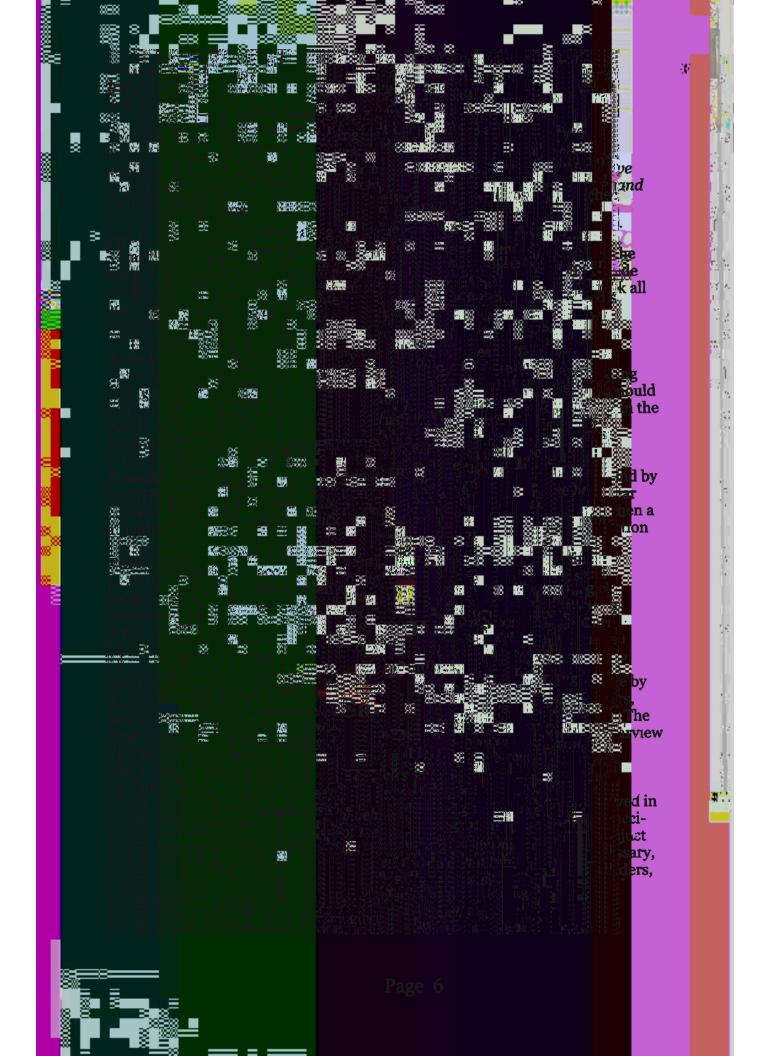
0251.PDF

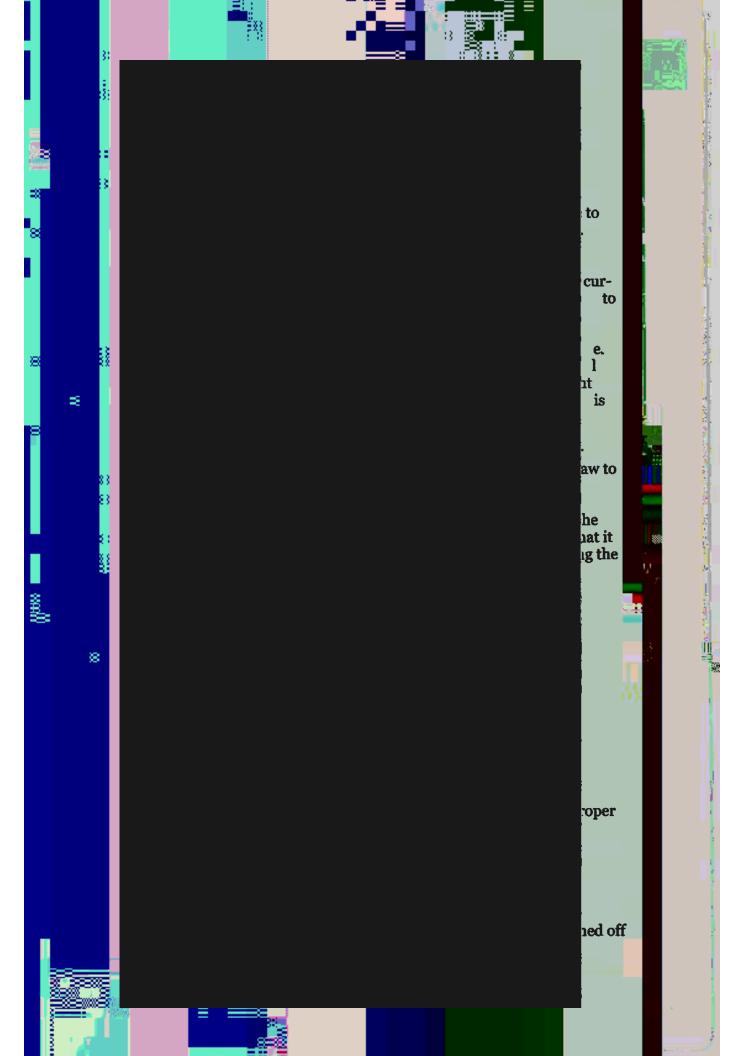


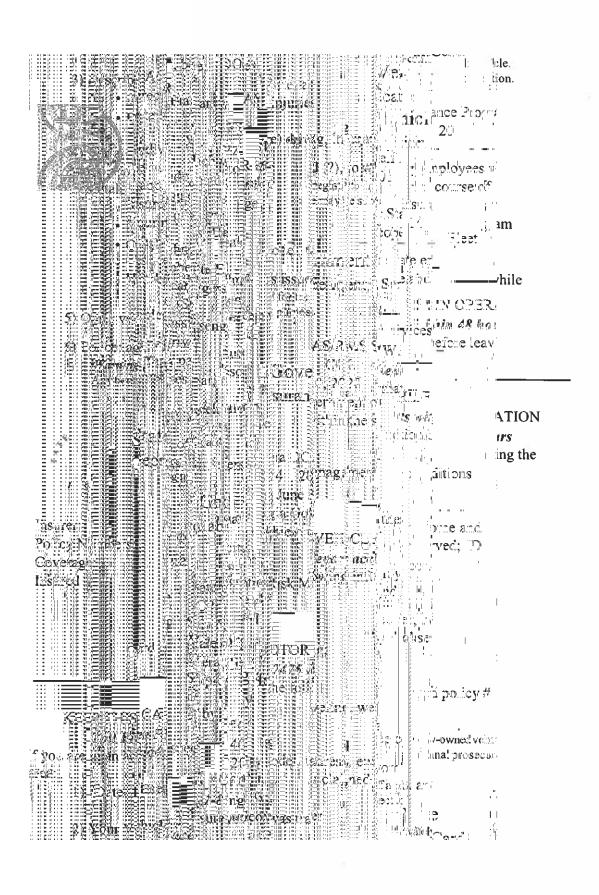












## VALDOSTA STATE UNIVERSITY VEHICLE ACCIDENT REPORT

!"#\$%&&'''|0\*+, -\$.\*(/, 0&\*, 1232\$.4\*5-3&63\*37/8\*, 123&63\*372\*-8\$/4)27/\$&#4-704/1/3.&42\$981\*3\*:/1/3.&;-41\$&)/!27+/8\*772, /3.84/#-4.(#,;

If involved in a vehicle accident, please complete as much information as possible and fax to Risk Management (229) 333-2159 within 24 hours of incident.

Accident Information					
1. Date of Incident		2. Incident Time	nt Time		
3. Incident Location		4. City and County			
3. Metacin Escation		4. City and County			
5. Description of the incident (Direction each vehicle	la rriac tu	ovaling wasthan conditions and d	atails of the agaident		
Continue on reverse if required)	ie was ir	avening, weather conditions, and do	etails of the accident.		
Continue on reverse in required)					
6. Police Authority Contacted	7. Off	icer's Name	8. Report #		
9. Citation(s) Issued		10. To Whom			
11 0 11 1		12 G . V.1: 1 D :			
11. State Vehicle Make		12. State Vehicle Driver Name			
Model		Address			
Tag #		Address			
VIN#		Home Phone			
		Work Phone			
		Department			
12 04 7/1:1 /16 4 4 1:1:		Injuries 14. Other Vehicle Driver			
13. Other Vehicle (If more than one other vehicle is involved, put info on reverse)		Name			
Make		Address			
Model					
Tag #		Home Phone			
Insurance Co.		Work Phone			
Policy #		Employer			
15. Passengers: If there were passengers in any of t	he vehic	Injuries	required for the vehicle		
driver on the reverse side.	ne venic	les, include the same information i	equired for the venicle		
16. Witness		17. Witness			
Name		Name			
Address		Address			
Phone		Phone			
		<del>-</del>			

NAME	PHONE NUMBER	

## **Accident Information Continuation Sheet**



## MOTOR VEHICLE USE PROGRAM SUPERVISOR'S ACCIDENT FOLLOW-UP CHECKLIST

Supervisors are to complete this checklist and forward it to the Risk Management Services Division (RMS) within 2 work days of being advised of an on-the-job accident that occurred while driving on state business.

DRIVER INFORMATION				
Name	Work Unit			
Date of Accident	Frequency of driving on state business			
	Weekly or more often			
	Infrequently			
CHECKLIST				
Meet with the Driver to discuss the details of the accident.				
<ul><li>□ Did the driver meet the following requirements?</li><li>□ Yes</li><li>□ No</li></ul>				
Requirem	Date			
Obtain all necessary information at the scene				
Call loss into 1-877-656-7475 or ARI within 48 hours				
Respond to any acknowledgements or requests sent by DOAS RMS				
Obtain the police report, if requested, and forward to DOAS RMS				
· · · · · · · · · · · · · · · · · · ·				
Discuss appropriate corrective action.	depending on whether the driver v	vas cited		
for the accident.				
Discuss appropriate corrective action, or	·	was cited		
ioi ine accident.				

3/2008 RMS101 Form-3