

**CITY OF LOS ANGELES
AUTOMOBILE ACCIDENT REPORT**

Supervisor:

1. All BCA employees must complete regardless how slight the injury or damage.
2. In case of injury or death immediately contact City Attorney Claims Division (213) 978-7050.
3. After hours, contact City Hall Operator at 311 (213) 978-3231 or (966) 452-2489
4. City owned vehicles need to be brought to GSD Fleet Services within 5 working days.

Distribution:

Signed original: BCA Time Keeper Copies: BCA Safety Engineer & employee [Both pages 1 & 2]
GSD Fleet Services & Personnel Dept – page 1 only

DATE OF ACCIDENT	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	LOCATION (Street, Freeway)	(City)
CITY VEHICLE GOING TO (ADDRESS)		COMING FROM (ADDRESS)	PURPOSE OF TRIP

PART I- CITY VEHICLE

DRIVER'S NAME			RESIDENCE ADDRESS	CITY	ZIP CODE	RES. PHONE NO.	DATE OF BIRTH
DEPARTMENT/BUREAU	SUPERVISOR'S NAME		BUSINESS ADDRESS (Building and Room No., Section)			MAIL STOP	BUS. PHONE NO. (Ext.)
MAKE	MODEL	YEAR	EQUIP. NO.	LICENSE NO.	REGISTERED OWNER	DRIVER LICENSE#	
MILEAGE VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF INSURANCE COMPANY			POLICY #	INS. CO. NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PASSENGER(S) 1. (Name)		(Address)			City Employee? <input type="checkbox"/> YES <input type="checkbox"/> NO		
2.					<input type="checkbox"/> YES <input type="checkbox"/> NO		
WAS ANY PERSON IN CITY VEHICLE INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WAS CITY VEHICLE DAMAGED? <input type="checkbox"/> YES <input type="checkbox"/> NO		POINTS OF IMPACT			
ODOMETER READING		PART OF VEHICLE DAMAGED					

PART II- OTHER VEHICLE

DRIVER'S NAME			ADDRESS	DRIVER LICENSE#	RES. PHONE NO.	AGE
EMPLOYER			EMPLOYER'S ADDRESS		BUS. PHONE NO. (Ext.)	
MAKE	MODEL	YEAR	LICENSE NO.	REGISTERED OWNER (Name & Address)		
INSURANCE COMPANY			POLICY #			
PASSENGER(S) 1. (Name)		(Address)			BUS. PHONE NO. (ext.)	RES. PHONE NO.
2.						
WAS OTHER VEHICLE DAMAGED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PART OF VEHICLE DAMAGED			WAS ANY PERSON IN OTHER VEHICLE INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PART III- PROPERTY DAMAGE (Other than vehicle)

LIST PROPERTY THAT WAS DAMAGED OR CLAIMED TO BE DAMAGED		
OWNER'S NAME	ADDRESS	PHONE NO.
DESCRIBE PROPERTY		

COMPLETE AND SIGN ORIGINAL ON BOTH PAGES

TYPED NAME AND TITLE OF PERSON FILING REPORT	EMPLOYEE SIGNATURE	DATE
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PART IV- WITNESSES

NAME	ADDRESS	BUS. PHONE NO. (ext.)	PHONE NO. (residence)

PART V- INJURIES

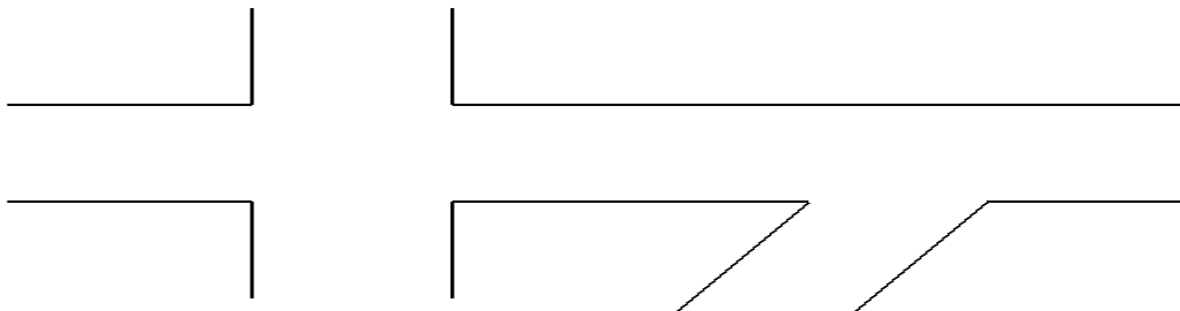
NAME OF PERSON(S) CLAIMING INJURY	(Address)	(Phone)	(Sex)	(Age)

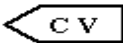
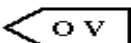
PART VI- DESCRIPTION OF ACCIDENT

L.A.P.D. INVESTIGATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF OTHER INVESTIGATING POLICE DEPARTMENT (If no investigation, indicate "NONE")		
DIRECTION CITY VEHICLE WAS TRAVELING	STREET	SPEED	SPEED
TRAFFIC CONTROL <input type="checkbox"/> NONE <input type="checkbox"/> STOP SIGN <input type="checkbox"/> SIGNAL <input type="checkbox"/> OTHER (Specify)	WAS TRAFFIC CONTROL OBEYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DIRECTION OTHER VEHICLE WAS TRAVELING	STREET	SPEED	SPEED LIMIT
TRAFFIC CONTROL <input type="checkbox"/> NONE <input type="checkbox"/> STOP SIGN <input type="checkbox"/> SIGNAL <input type="checkbox"/> OTHER (Specify)	WAS TRAFFIC CONTROL OBEYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
WEATHER CONDITION	<input type="checkbox"/> DAY <input type="checkbox"/> NIGHT	VISIBILITY <input type="checkbox"/> GOOD <input type="checkbox"/> POOR	

Describe the facts of the accident in detail.

DIAGRAM OF ACCIDENT



LEGEND CITY VEHICLE 	OTHER VEHICLE 	EMPLOYEE SIGNATURE	DATE
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SUPERVISOR'S COMMENT

SUPERVISOR'S SIGNATURE	DATE
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