



August 29, 2011

TO: All ANR Drivers

FROM: Brian Oatman, ANR Risk & Safety Services

RE: ANR Vehicles

This letter is to inform UC ANR employees of the procedures they should follow in the event of an accident or breakdown while driving an ANR vehicle. An ANR vehicle is defined as any vehicle that is owned or leased by the Division. Please maintain a copy of this letter and all its attachments in each car that meets the above definition. These procedures do not apply to county-owned vehicles or those rented from a UC campus. Use the procedures from the County or campus fleet services for those vehicles.

Insurance:

UC-owned vehicles are covered by the University's self-insurance program, which provide coverage for officers, employees and agents (formal volunteers) of the University while acting within the course and scope of their employment or volunteerism. Coverage is provided for activities that are scheduled, sponsored, and supervised by the University. More information on this can be found at <http://www.ucanr.org/risk>. Supplement A of this document is a copy of the Certificate of Self-Insurance, with the address where claims can be sent.

Leased Cars from Enterprise Fleet Management – These cars are insured through Enterprise, therefore any claims involving these vehicles need to be reported to:

Protective Insurance Company
(800) 325-8838
Policy # LE001009390751

Accident/Incident Reports:

In the event of an accident, first make sure that everyone involved is safe and receiving medical attention if needed. Within 48 hours of the accident, please complete Supplement B "ANR Incident Report". Fill out all sections that pertain to the accident without including opinion or speculation. If possible take pictures of the surrounding area, vehicle(s), and property involved in the accident and any observed damage. Also a diagram of the scene can be provided to help explain the accident (Supplement C). If an ANR employee is injured fill out the UCD Employer's Report of Occupational Injury or Illness (Supplement D). Please send any reports, attachments, and/or photos to olharris@ucdavis.edu or baotman@ucdavis.edu.

Additionally, the California DMV SR-1 “Accident Form” (Supplement E) needs to be filled out if one of the following conditions is met:

- There was property damage of more than \$750 **or**
- Anyone was injured (no matter how minor) **or**
- Anyone was killed.

ANR drivers of a **UC-owned vehicle** are exempt from filling a DMV SR-1 (*California Vehicle Code, Section 16000, Paragraph (b)*)

If you were driving a UC-owned vehicle and receive a request from DMV or a law enforcement officer to complete an SR-1 form after an accident, please respond that you were driving a University vehicle on official University business and that the University is exempt from the filing requirement. Further inquiries may be forwarded to the ANR Risk & Safety Services at (530) 752-7481 or emailed to: olharris@ucdavis.edu or baotman@ucdavis.edu.

If applicable each driver of a **personal, leased, or rented car** must make a report to DMV within **10 days**, no matter who caused the accident, even if the accident occurred on private property. Mail the completed report form to DMV at the address on the form. Also send a copy to: olharris@ucdavis.edu or baotman@ucdavis.edu.

Repair & Emergency Services:

The following services can be obtained depending on the vehicle:

	UC Vehicles	Enterprise Vehicles
Gas	<ul style="list-style-type: none"> • Use Voyager card 	<ul style="list-style-type: none"> • Use Voyager card
Repair & Services	<ul style="list-style-type: none"> • Voyager card can be used for emergency repairs up to \$250. • Over \$250 needs to contact Risk & Safety Services for approval. <ul style="list-style-type: none"> ○ Brian Oatman (530) 304-2054 ○ Mark Barros (530) 304-1015 	<ul style="list-style-type: none"> • Contact Enterprise National Service Department (NSD) for an authorized repair location prior to receiving service. • (800) 325-8838 <i>Use the Enterprise Full Maintenance card to pay for service</i>
Emergency Roadside Services	<ul style="list-style-type: none"> • Contact National Auto Club • (800) 600-6065 <i>Pay with Voyager card</i> 	<ul style="list-style-type: none"> • Contact Enterprise NSD • (800) 325-8838 <i>Use the Enterprise Full Maintenance card to pay for service</i>

Safety:

All employees that drive for business should receive some type of safe driver training. ANR Risk & Safety Services has identified or developed several resources for safe driver training which can be found at: http://safety.ucanr.org/Programs/Driver_Safety/

Supplement A – Certificate of Self-Insurance

Supplement B – ANR Incident Report

Supplement C – Diagram Form

Supplement D – UCD Employer's Report of Occupational Injury or Illness

Supplement E – CA DMV SR1 Form

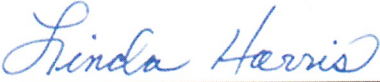
University of California
Office of Risk Services
Ag Field Station Building
One Shields Avenue
ANR Research & Extension Centers
Davis, CA 95616-8593
(530) 752-7481

UNIVERSITY OF CALIFORNIA CERTIFICATE OF SELF-INSURANCE

This is to certify that the University of California is self-insured for the following coverage:

Type of Coverage	Self-Insured Limits
I. AUTOMOBILE LIABILITY Vehicles Owned, Non-owned and Hired	\$1,000,000 each occurrence
II. TERMS & CONDITIONS: This certificate evidences automobile liability coverage for vehicles owned, non-owned, operated, or hired by the University of California while in the course and scope of approved University activities.	

DATE ISSUED: August 29, 2011



AUTHORIZED SIGNATURE
Linda Harris
Risk Services Analyst
Division of Agriculture & Natural Resources



INCIDENT REPORT

Please submit this form within 48 hours

Date/Time of Incident: _____ AM PM Date/Time Incident Report Completed: _____ AM PM

Party 1 Information

Party's Name: _____ Home Telephone: _____
 Party's Address: _____ Work Telephone: _____
 Party's Affiliation: UC Employee County Employee Contract Employee Volunteer 4-H Member Other: _____
Vehicle Information (use this section for auto accidents):
 Year: _____ Make: _____ Model: _____ License#: _____
 Vehicle Ownership: ANR Leased FEPP Personal _____ Campus _____ County
 Specify type of damage to vehicle (Where & Type): _____
 Property Damage (use only if there is property involved) _____

Use the space provided at the end of this report to describe the incident

Party 2 Information

Party's Name: _____ Home Telephone: _____
 Party's Address: _____ Work Telephone: _____
 Party's Affiliation: UC Employee County Employee Contract Employee Volunteer 4-H Member Other: _____
Vehicle Information (use this section for auto accidents):
 Year: _____ Make: _____ Model: _____ License#: _____
 Insurance Carrier: _____ Policy # _____
 Vehicle Ownership: ANR Leased FEPP Personal _____ Campus _____ County
 Specify type of damage to vehicle (Where & Type): _____
 Property Damage (use only if there is property involved) _____

Use the space provided at the end of this report to describe the incident

Party 3 Information

Party's Name: _____ Home Telephone: _____
 Party's Address: _____ Work Telephone: _____
 Party's Affiliation: UC Employee County Employee Contract Employee Volunteer 4-H Member Other: _____
Vehicle Information (use this section for auto accidents):
 Year: _____ Make: _____ Model: _____ License#: _____
 Insurance Carrier: _____ Policy # _____
 Vehicle Ownership: ANR Leased FEPP Personal _____ Campus _____ County
 Specify type of damage to vehicle (Where & Type): _____
 Property Damage (use only if there is property involved) _____

Use the space provided at the end of this report to describe the incident

Medical Treatment Information (if applicable)

Was First Aid administered? Yes No If yes, by whom? _____
 Did the injured party(ies) receive medical treatment beyond first aid? Yes No If yes, date and time injured party(ies) sought medical attention: _____ AM PM
 Medical Care Provider Name (hospital/physician): _____
 Address: _____ Telephone: _____

This form is intended for documentation of major or minor injuries of non ANR employees, accidents, property damage or loss, and near-miss incidents. This is not a substitute for Workers' Compensation injury reporting forms. Promptly report all injuries or illnesses to your supervisor. Submit completed form to ANR Risk Services as soon as possible, but no later than 48 hours after the incident. See instructions on last page.

Use this section if more than one party

Use this section if more than two parties



INCIDENT REPORT

Location where incident occurred (street address or building/room #):

Nature of Injury (list parts of body affected and type of injury, i.e., sprained right ankle):

Describe how the incident occurred (please just list the facts as you know them; do not speculate as to the cause of the incident):

Witness Information (if applicable)

Name, address and telephone number of witnesses (witnesses may be contacted by Risk Services or other UC officials to investigate the incident):

Police or Other Agency Report (if applicable)

Was a police report filed? Yes No

Reporting Agency: _____ Report #: _____

Officer Name: _____ Badge #: _____

Reporting Party Information

Reporting Party Name: _____ Home Telephone: _____

Title/Job Classification: _____ Work Telephone: _____

ANR Office/Location: _____

Reporting Party Affiliation: UC Employee County Employee Contract Employee Volunteer Other: _____

Name of Supervisor: _____ Telephone: _____

Reporting Party Signature: _____ Date: _____

This is a CONFIDENTIAL report to provide information for use by ANR Risk Services, legal counsel, and the University's insurers in the event a claim is filed against the Regents of the University of California or its employees. This information should not be given to anyone except authorized University officials or agents.

Use this section to provide additional information or details. Please attach any photos, diagrams, or other related documents

Instructions for Completing ANR Incident Report Form:

General Guidelines

This form is intended to record the initial facts of an incident. Only fill out the sections that apply to your incident/accident. Attach additional sheets as needed to describe the incident. Please do not include opinion or speculation in the report. You are not expected to conduct an investigation of the incident. If an investigation is warranted, it will be conducted by another agency (i.e.: police, fire department, insurance company, etc.) or initiated by UC ANR Risk Services. This form will be kept confidential and only used by UC officials or agents acting on behalf of the University. If you have any questions about this form, contact Risk Services at (530) 752-7481.

When should this form be used?

To report any incident, accident or near miss involving ANR employees, volunteers, 4-H members, or property. The form is for either severe or minor incidents, including motor vehicle accidents. The form can be used to report injuries to non-employees (i.e.: volunteers, youth members, visitors). Employee injuries should be reported using the [UCD Employer's Report of Occupational Injury or Illness](#).

Who should use this form?

Any ANR affiliate (employee, volunteer, etc.) may use this form.

What if I do not have all of the requested information?

Fill out the form as completely as possible, but it is understood that some information may not be applicable or available in many cases. Please submit basic information within 48 hours, you can amend the report later if more information becomes available.

Who should I call about the incident?

Report to the incident to your immediate supervisor as soon as practical. If they are not available call the Risk Services Office at (530) 752-7481.

What do I do with the completed form?

Volunteers or other non-employees - submit the completed form to your UC Cooperative Extension (UCCE) County Office.

Employees - retain a copy of the completed form at your office and submit the completed form to:

ANR Risk Services

Ag. Field Station Bldg.

One Shields Ave.

Davis, CA 95616

Telephone: (530) 752-7481

Fax: (530) 752-3930

e-mail: olharris@ucdavis.edu

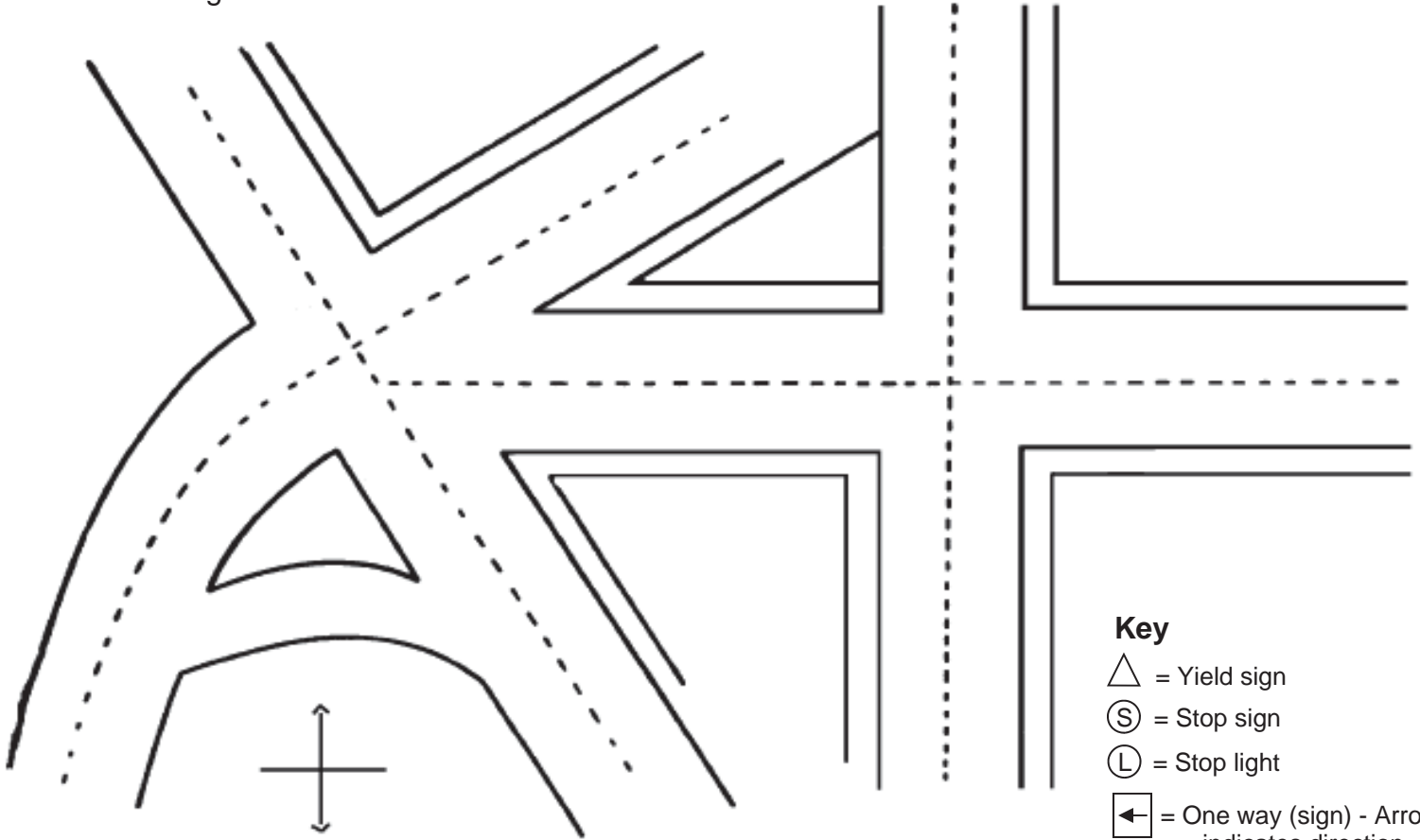
Where do I obtain a copy of the Incident Report form?

You may obtain copies of the Incident Report form from any CE County Office or on the internet at:

<http://ucanr.org/risk>

Note: 4-H members, 4-H adult volunteers, or Master Gardener volunteers may be eligible for "Accident and Sickness" Coverage through an Accident Insurance Program policy with Hartford Life & Accident Insurance Company. See your local County office to obtain the Hartford claim form. Please fill out this incident report in addition to the Hartford claim form.

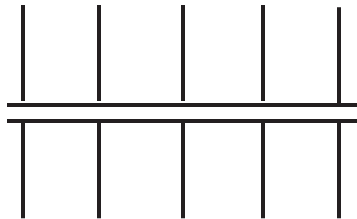
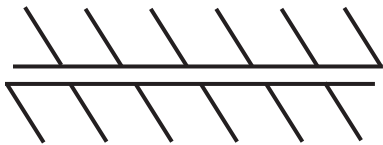
Accident Diagram



Key

- △ = Yield sign
- Ⓢ = Stop sign
- Ⓛ = Stop light
- ◀ = One way (sign) - Arrow indicates direction
- W = Witness
- ⊆ = Pedestrian
- ⊗ = Your vehicle
- ⊕ ⊙ = Other vehicle(s)

Parking lot / Garage



Show position of vehicle(s) and the direction of travel. Show all traffic signs and signals relevant to the accident. Note any obstructions and/or road surface type and condition. Feel free to add or create a new diagram as needed. Comments can be made to describe what happened or to clarify your diagram. If you add symbols to your diagram, enter the description in the symbol key.

UCD Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED.

In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA	Employee Name:		Employee's UC Davis ID #:		
	Address:		Home Phone: ()		
	City/State/Zip:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	
	Department/Location:		Employee's Work Phone: ()		
	Payroll Title/TC:		Date of Hire:	Annual Gross Salary: \$	
	Supervisor's Name:		Supervisor's Work Phone: ()		
	Employee () Volunteer () Student-Employee ()		() hours per day	() days per week	() total weekly hours

EMPLOYEE STATEMENT	Specific Injury/Illness/Exposure:		Body Part(s) affected:	Date of injury/illness:	
	Location where injury or illness occurred:			Others Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	What equipment, materials or chemicals caused the injury/illness? :			Who witnessed this injury?	
	Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.				
	Medical Treatment provided by: <input type="checkbox"/> Employee Health Services <input type="checkbox"/> Sutter Davis Hospital ER Other: (Provide Name & Phone #) _____ <input type="checkbox"/> Private Physician <input type="checkbox"/> UC Davis Medical Center <input type="checkbox"/> First Aid, no medical care needed.				
	Employee Signature:			Today's Date:	

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER	After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:	
	What was the injury, illness or exposure?	

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES	PREVENTIVE ACTIONS
<input type="checkbox"/> Struck by or against object (indicate) <input type="checkbox"/> Caught in/under/ between <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid exposure: <input type="checkbox"/> Needle stick <input type="checkbox"/> Sharps <input type="checkbox"/> Animal bite <input type="checkbox"/> Other, Explain _____ _____ _____ _____	Equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job Personal protective equipment <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for the task <input type="checkbox"/> Personal protective equipment failure Training/Experience <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, not followed <input type="checkbox"/> New task for employee or lack of experience Work Area <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting or noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temp. etc) Use additional pages as needed	<input type="checkbox"/> Ventilation issues <input type="checkbox"/> Ergonomic factors Employee <input type="checkbox"/> Physically not able to do work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Incorrect procedures used for task <input type="checkbox"/> Other unsafe practice Assistance <input type="checkbox"/> Difficult to perform task without help <input type="checkbox"/> Safety features or devices not readily available <input type="checkbox"/> Assistive devices not used <input type="checkbox"/> Lack of policy/procedure <input type="checkbox"/> Animal (explain below) <input type="checkbox"/> Other (explain) _____ _____ _____ _____
SUPERVISOR WILL: <input type="checkbox"/> Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan <input type="checkbox"/> Request ergonomic evaluation <input type="checkbox"/> Order new equipment <input type="checkbox"/> Order new personal protective equipment <input type="checkbox"/> Remove equipment from use and repair/replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Will retrain employee before task is re-assigned. <input type="checkbox"/> Perform on-site review of work activity, update job safety analysis. <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others in job category. <input type="checkbox"/> Other _____ _____ Preventive actions will be completed by: Name _____ Expected date of completion _____		

SUPERVISOR'S OR MANAGER'S SIGNATURE:		Date of Investigation:
DEPARTMENT HEAD'S SIGNATURE:		Date:



REPORT OF TRAFFIC ACCIDENT OCCURRING IN CALIFORNIA

READ IMPORTANT INFORMATION ON BACK

DMV USE ONLY

AS APPROPRIATE, PLEASE TYPE OR PRINT IN BOXES

# OF VEHICLES	DATE OF ACCIDENT	ACCIDENT LOCATION - CITY/COUNTY (CALIFORNIA ONLY)			ON PRIVATE PROPERTY <input type="checkbox"/> Yes <input type="checkbox"/> No
REPORTING PARTY'S INFORMATION	TIME OF ACCIDENT Hour _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Moving <input type="checkbox"/> Stopped in Traffic <input type="checkbox"/> Parked <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicyclist <input type="checkbox"/> Other (E.G., ROLLAWAY)			DRIVING FOR EMPLOYER <input type="checkbox"/> Yes <input type="checkbox"/> No
	DRIVER'S NAME (FIRST, MIDDLE, LAST)			DRIVER LICENSE NUMBER	STATE
	DRIVER'S STREET ADDRESS				DATE OF BIRTH
	CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk () Hm ()	
	VEHICLE (YEAR AND MAKE)	VEHICLE LICENSE PLATE OR VEHICLE IDENTIFICATION NUMBER		STATE	DAMAGES OVER \$750 <input type="checkbox"/> Yes <input type="checkbox"/> No
	VEHICLE OWNER—PERSON OR COMPANY				DATE OF BIRTH
	ADDRESS			CITY	STATE ZIP CODE
	INSURANCE COMPANY NAME (NOT AGENT OR BROKER) AT THE TIME OF THE ACCIDENT			POLICY NUMBER	
	COMPANY NAIC NUMBER	POLICY PERIOD From: _____ To: _____	POLICY HOLDER NAME		
	OTHER PARTY'S INFORMATION	<input type="checkbox"/> Moving <input type="checkbox"/> Stopped in Traffic <input type="checkbox"/> Parked <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicyclist <input type="checkbox"/> Other (E.G., ROLLAWAY)			DRIVING FOR EMPLOYER <input type="checkbox"/> Yes <input type="checkbox"/> No
DRIVER'S NAME (FIRST, MIDDLE, LAST)			DRIVER LICENSE NUMBER	STATE	
DRIVER'S STREET ADDRESS				DATE OF BIRTH	
CITY		STATE	ZIP CODE	TELEPHONE NUMBERS Wk () Hm ()	
VEHICLE (YEAR AND MAKE)		VEHICLE LICENSE PLATE OR VEHICLE IDENTIFICATION NUMBER		STATE	DAMAGES OVER \$750 <input type="checkbox"/> Yes <input type="checkbox"/> No
VEHICLE OWNER—PERSON OR COMPANY				DATE OF BIRTH	
ADDRESS			CITY	STATE ZIP CODE	
INSURANCE COMPANY NAME (NOT AGENT OR BROKER) AT THE TIME OF THE ACCIDENT			POLICY NUMBER		
COMPANY NAIC NUMBER		POLICY PERIOD From: _____ To: _____	POLICY HOLDER NAME		
INJURY/DEATH PROPERTY DAMAGE		NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED			<input type="checkbox"/> Injured
				<input type="checkbox"/> Deceased	<input type="checkbox"/> Bicyclist <input type="checkbox"/> Pedestrian
	NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED			<input type="checkbox"/> Injured	<input type="checkbox"/> Driver <input type="checkbox"/> Passenger
				<input type="checkbox"/> Deceased	<input type="checkbox"/> Bicyclist <input type="checkbox"/> Pedestrian
	OTHER PROPERTY DAMAGED (TELEPHONE POLES, FENCE, LIVESTOCK, ETC.)			DAMAGES OVER \$750 <input type="checkbox"/> Yes <input type="checkbox"/> No	
PROPERTY OWNER'S NAME AND ADDRESS					

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE	PRINTED NAME	SIGNATURE X
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ADDITIONAL INFORMATION ATTACHED

A YOUR VEHICLE**CALIFORNIA INSURANCE INFORMATION****DO NOT DETACH****DMV FILE NUMBER**The Department may send this part to the **insurance company** indicated. If not **fully completed**, it will be assumed you were **not** insured for the accident and **your license will be suspended**.

I N S U R A N C E	NAME OF INSURANCE COMPANY (NOT AGENCY OR BROKERAGE) THAT ISSUED THE LIABILITY POLICY COVERING THE OPERATION OF YOUR VEHICLE				
	POLICY NUMBER		POLICY PERIOD From: _____ To: _____		
	DATE OF ACCIDENT	IN OR NEAR (CITY OR TOWN) (CALIFORNIA ONLY)			DRIVER LICENSE NUMBER (DRIVER OF YOUR VEHICLE)
	VEHICLE (YEAR AND MAKE)		VEHICLE IDENTIFICATION NUMBER		VEHICLE LICENSE PLATE NUMBER STATE
	DRIVER		ADDRESS		
	OWNER		ADDRESS		
	FULL NAME OF POLICY HOLDER		ADDRESS		

SR 1A (REV. 9/2008) WWW

If the policy was not in effect, this form must be completed and returned to the Department within 20 days.

The undersigned company advises that with respect to the reported accident, the policy reported on the reverse side:

 WAS NOT IN EFFECT Was not a liability policy Did not cover the vehicle/driver Number is not a company policy number

Policy Number _____ Policy Period from _____ to _____

Signature _____

Title _____

Date _____

MAIL TO:
 Department of Motor Vehicles
 Financial Responsibility
 P. O. Box 942884
 Sacramento, CA 94284-0884

SR 1A (REV. 9/2008) WWW

IMPORTANT INFORMATION

California law requires *traffic accidents* on a California street/highway or private property to be reported to the Department of Motor Vehicles (DMV) within 10 days if there was an injury, death *or* property damage in excess of \$750. Untimely reporting could result in DMV suspending a driver license. Accidents involving vehicles *not required to be registered* such as an off-road vehicle (OHV), implement of husbandry, or snowmobile **or** occurring on a military base **or** occurring on the driver's *own* property involving *only* the personal property of the driver *and* there was no injury or death are not reportable.

The law requires the driver to file **this SR-1 form** with DMV **regardless of fault**. This report must be made in addition to any other report filed with a law enforcement agency, insurance company, or the California Highway Patrol (CHP) as their reports **do not** satisfy the filing requirement. An insurance agent, attorney, or other designated representative may file the report for the driver.

The law requires every driver and every owner of a motor vehicle to be "financially responsible" for any injury or damage resulting from operating or owning a motor vehicle. The minimum insurance level for "financial responsibility" is **public liability and property damage coverage** of \$15,000 for injury or death of one person, \$30,000 for injury or death of two or more persons and \$5,000 property damage per accident. Comprehensive and collision insurance **does not meet the legal requirement**.

§1806 of the California Vehicle Code (CVC) requires the DMV to record accident information **regardless of fault** when individuals report accidents under the Financial Responsibility Law or if law enforcement agencies or CHP investigate and make a report.

WHEN COMPLETING THIS FORM...

Please print within the spaces and boxes on this form. If you need to provide additional information on a separate piece of paper(s) or you include a *copy* of any law enforcement agency report, please check the box to indicate 'Additional Information Attached'. **If you are the passenger reporting the accident**, be sure to identify yourself by using the 'other' box and stating 'passenger' in the explanation.

- Write **unk (for unknown)** or **none** in any space or box when you do not have information on the other party involved.
- Give insurance information that is complete and which *correctly* and *fully* identifies the **company** that *issued* the policy.
- Place the correct National Association of Insurance Commissioners (NAIC) number for your insurance company in the boxes provided. The NAIC number should be located on your insurance ID card or you can contact your insurance agent or company for the information.
- Identify any person involved in the accident (driver, passenger, bicyclist, pedestrian, etc.) who you saw was injured *or* complained of bodily injury or know to be deceased.
- Record in the OTHER PROPERTY DAMAGED section any damage to telephone poles, fences, street signs, guard posts, trees, livestock, dogs, etc., meeting the filing requirement, including amount. *This may require that you contact the owner of the property for an estimate of damages.*
- Once you have completed this report, please mail it to:

**DEPARTMENT OF MOTOR VEHICLES
FINANCIAL RESPONSIBILITY
MAIL STATION J237
P.O. BOX 942884
SACRAMENTO, CA 94284-0884**

DMV does not accept reports or take actions against non-reporting or uninsured motorists unless this SR-1 form is sent to DMV by someone involved in the accident or their designee and the report is received by DMV *within one calendar year of the accident date*.

ADVISORY STATEMENT

The accident information on the SR-1 is required under the authority of Divisions 6 and 7 of the California Vehicle Code. Failure to provide the information will result in suspension of the driving privilege. Except as made confidential by law (e.g., medical information) or exempted under the Public Records Act, the information is a public record, is regularly used by law enforcement agencies and insurance companies, and is open to public inspection. §16005 CVC limits the public record for SR-1 reports to accident involvement, but does allow persons with a proper interest (involved drivers, their employers, etc.) to receive specified information. Individuals may inspect or obtain copies of information contained in their records during regular office hours. The Financial Responsibility Section Manager, 2570 24th Street, Sacramento, CA 95818 (telephone number: 916-657-6677) is responsible for maintaining this information.