

COUNTY OF LOS ANGELES REPORT OF VEHICLE COLLISION or INCIDENT

FATALITIES OR SERIOUS INJURIES MUST BE REPORTED IMMEDIATELY BY TELEPHONE TO CARL WARREN & CO. (818) 247-2206

Prepared for County Counsel in defense of the County, Special Districts and Employees

VEHICLE DRIVEN BY EMPLOYEE (check one)			
Dept. Name: _____	Dept. #: _____	<input type="checkbox"/> COUNTY VEHICLE <small>(Includes Veh. Leased or rented by CO.)</small>	<input type="checkbox"/> EMPLOYEE'S VEHICLE
DIV. Or Facility: _____	SECTION: _____	Equip. No. _____	License No. _____
RMIS Code #: _____		Insurance Co. _____	Policy No. _____
		Permittee <input type="checkbox"/> Yes <input type="checkbox"/> No	CONTRACT CITIES SERVICES <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name of contract city _____
POLICE REPORT <input type="checkbox"/> YES <input type="checkbox"/> NO		POLICE AGENCY REPORTING _____ STATION _____ REPORT # _____	
INCIDENT DATE _____ CITY _____ ON _____ AT _____ <small>(Street or Highway)</small>			
HOUR _____ AM _____ PM _____ OR AREA _____			
7 CI BHM DRIVER (1)	DRIVER: _____ Job Title _____ Driver's Lic. No. _____		
	Address: Home _____ Phone _____		Phone _____ Ext. _____
	Work Location _____		Phone _____ Ext. _____
	VEHICLE: Year _____ Make _____ Model or Type _____ Lic. No. _____ Parts Damaged _____		
OTHER DRIVER (2)	DRIVER _____		
	DRIVER'S LICENSE NO. _____ STATE _____ INSURANCE CO. _____ POLICY NO. _____		
	EMPLOYER _____ <small>(Name of Person, Company, or Organization) (Address) (City) (State) (Zip Code) (Phone)</small>		
	VEHICLE _____ Veh. Lic. No. _____ <small>(Year) (Make) (Model or Type) (Year) (Number) (State)</small>		
OTHER DRIVER (3)	PARTS DAMAGED _____		
	REGISTERED OWNER _____ <small>(Name) (Address) (City) (State) (Zip Code) (Phone)</small>		
	PASSENGER: _____ CO. Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	PASSENGER: _____ CO. Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
INJURED / WITNESSES	DRIVER _____		
	DRIVER'S LICENSE NO. _____ STATE _____ INSURANCE CO. _____ POLICY NO. _____		
	EMPLOYER _____ <small>(Name of Person, Company, or Organization) (Address) (City) (State) (Zip Code) (Phone)</small>		
	VEHICLE _____ Veh. Lic. No. _____ <small>(Year) (Make) (Model or Type) (Year) (Number) (State)</small>		
INJURED / WITNESSES	PARTS DAMAGED _____		
	REGISTERED OWNER _____ <small>(Name) (Address) (City) (State) (Zip Code) (Phone)</small>		
	PASSENGER: _____ CO. Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	PASSENGER: _____ CO. Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
INJURED / WITNESSES	Check one: <input type="checkbox"/> INJURED <input type="checkbox"/> WITNESS <input type="checkbox"/> FATALITY		
	NAME _____ PHONE _____		NATURE OF INJURY _____
	ADDRESS _____		TAKEN TO _____
	Check one: <input type="checkbox"/> INJURED <input type="checkbox"/> WITNESS <input type="checkbox"/> FATALITY		
INJURED / WITNESSES	NAME _____ PHONE _____		NATURE OF INJURY _____
	ADDRESS _____		TAKEN TO _____
	Check one: <input type="checkbox"/> INJURED <input type="checkbox"/> WITNESS <input type="checkbox"/> FATALITY		
	NAME _____ PHONE _____		NATURE OF INJURY _____
INJURED / WITNESSES	ADDRESS _____		TAKEN TO _____
	Check one: <input type="checkbox"/> INJURED <input type="checkbox"/> WITNESS <input type="checkbox"/> FATALITY		
INJURED / WITNESSES	NAME _____ PHONE _____		NATURE OF INJURY _____
	ADDRESS _____		TAKEN TO _____

INSTRUCTIONS: Complete form within 24 hours of vehicle collision and submit to your supervisor.
If more space is needed to completely answer any category on this form, attach an additional sheet.



**INDICATE
NORTH**

DRAW A DIAGRAM AND SHOW HOW COLLISION OCCURRED

Show your Vehicle as 1 the other Vehicles as 2, 3, etc.

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SHOW the location and position of Vehicle (s) at point of impact.
SHOW the name of the street(s) and location of stop signs, signals.
STATE number of lanes and length of skidmarks.

Co. Vehicles
Involved _____

EXPLAIN CLEARLY HOW COLLISION OCCURRED. USE ADDITIONAL SHEETS IF NECESSARY (IF SHERIFF DEPT., STATE IF MDT RELATED?)

DISTRIBUTION:

Department procedure for distribution to be followed; copies must be forwarded to the following:

ORIG CO: CARL WARREN & CO., P.O. Box 116, Glendale, CA 91209-0116
1 COPY - (If CO. Vehicle damaged) Internal Services Dept., 1100 N. Eastern Ave., Room 210, L.A. 90063
(Not applicable for Road and Flood Control Vehicles)

(9) WEATHER

- _____ Clear
- _____ Rain
- _____ Fog
- _____ Dusty
- _____ Snow
- _____ Heavy Smog
- _____ Other

(11) EVASION ACTION

- by CO. Driver
- _____ Locked Brakes
- _____ Hard Brakes
- _____ Slowed/Stopped
- _____ Steered Away
- _____ Accelerated
- _____ None
- _____ Other

(1) LOCALITY

- _____ Rural-Hwy/Roadway
- _____ Residential
- _____ Business/Shopping
- _____ Freeway
- _____ Motor Way (Mtn.)
- _____ Open Field
- _____ Private Road
- _____ Other

(3) MOVEMENT

- 1 2
- _____ Straight Ahead
- _____ Lane Change
- _____ Making Right Turn
- _____ Making Left Turn
- _____ Standing
- _____ Parked
- _____ Backing
- _____ Rolling Back
- _____ Moving Unattended

(5) AMOUNT OF TRAFFIC

- _____ No Other
- _____ Light
- _____ Medium
- _____ Heavy-Flowing
- _____ Congested

(7) ROAD SURFACE

- _____ Concrete
- _____ Asphalt
- _____ Oiled/Gravel
- _____ Unpaved
- _____ Other

(6) TERRAIN

- _____ Level
- _____ Upgrade
- _____ Downgrade
- _____ Hill Crest
- _____ Dip

(8) VISIBILITY

- _____ Good
- _____ Fair
- _____ Poor
- _____ Very Poor

(10) ROAD CONDITION

- _____ Dry
- _____ Wet
- _____ Muddy
- _____ Snowy or Icy

(12) SAFETY BELTS

- _____ Installed, Not Worn
- _____ Installed and Worn
- _____ Not Installed
- _____ Vehicle Unoccupied

(2) OPERATING AREA

- _____ Non-intersection
- _____ Nearing Intersection
- _____ In Intersection
- _____ Leaving Intersection
- _____ Entering Driveway
- _____ Leaving Driveway
- _____ Construction Zone
- _____ Parking/Bus. Lot
- _____ Other

(4) TRAFFIC CONTROLS

- _____ None Present
- _____ Green Signal
- _____ Yellow Signal
- _____ Red Signal
- _____ Flashing Signal
- _____ Stop Sign
- _____ Warning Sign
- _____ Construction Sign
- _____ Other

(13) EMERGENCY RESPONSE

(Applies to Vehicle driven by employee)

Were red lights and siren activated? Yes No

County Driver's Item No. _____ Employee No. _____ Age _____

Total Yrs. Driv. _____ Total Yrs. Driv. for CO. _____ Total Yrs. this type Veh. _____

SIGNATURE OF EMPLOYEE DATE

SIGNATURE OF SUPERVISOR DATE

SIGNATURE OF DEPT. HEAD OR AUTH. REPRESENTATIVE DATE