PERSON(S) INJURED

1. Name _____ Age_____

Address

_____

_____

Type of Injury _____

Where taken after the collision? _____

_____

By Ambulance? _____ By Whom? _____

_____

2. Name _____ Age_____

Address

_____

_____

Type of Injury _____

Where taken after the collision? _____

_____

By Ambulance? _____ By Whom? _____

_____

Comments about collision: _____

_____

_____

EVIDENCE OF INSURANCE

You may be called upon to provide the following information to satisfy the requirement to show proof of insurance.

The City of Fairfield is permissibly self insured by the State of California.

HEART OF SOLANO COUNTY
FAIRFIELD
CALIFORNIA

CITY OF FAIRFIELD
SELF INSURED

CONTACT: Laura Marquez
Senior Human Resources Analyst
(707) 428-7397

Human Resources
(707) 428-7394

IN CASE OF COLLISION

Driver

1. Stop at once. Notify your supervisor immediately.
2. Call 911 and request police assistance. If anyone is injured, ask for a doctor and ambulance.
3. Take steps to prevent further collisions
4. Protect your passengers, your vehicle, and/or cargo.
5. Obtain names and addresses of witnesses.
6. Give other driver(s) your name, address, company name (City of Fairfield), company address, vehicle unit number, and your driver's license number.
7. Discuss the specifics of the collision ONLY with the police of City representative. DO NOT admit responsibility to a third party.
8. Complete the driver's report at the scene of the collision, if possible.
9. Submit the completed report and collision questionnaire to your supervisor immediately.
10. Use multiple forms or an attachment if more space is needed to provide collision information

DRIVER'S REPORT

The Collision

Date: _____ Time: _____

Unit Number: _____ Department: _____

Location: _____
_____

Light Conditions: □ Daylight □ Dusk
□ Dawn □ Dark
Weather: □ Rain □ Clear □ Fog
Road Surface: □ Dry □ Wet
Highway: □ Divided □ Undivided

Number of lanes: _____

OTHER DRIVER(S) AND VEHICLE(S)

1. Name of Owner: _____

Address:_____

City/State/ZIP: _____

Name of Driver: _____

Address: _____

City/State/ZIP: _____

Driver License No.: _____ State:____
Make/Model of Vehicle _____ Year: ___
License Plate _____ State: ___

Insured by: _____
Phone Number:_____
Policy Number: _____
Number of persons in vehicle: _____
Type of Damage: _____
_____

2. Name of Owner: _____

Address:_____

City/State/ZIP: _____

Name of Driver: _____

Address: _____

City/State/ZIP: _____

Driver License No.: _____ State:____
Make/Model of Vehicle _____Year: ___
License Plate _____ State: ___

Insured by: _____
Phone Number: _____
Policy Number: _____
Number of persons in vehicle: _____
Type of Damage: _____
_____

DRIVER INFORMATION

Name: _____

Address:_____

City/State/ZIP: _____

Driver's License Number: _____

Number of persons in vehicle: _____

Type of Damage: _____

Investigating Officer/Badge Number: _____
_____

Name of Investigating Agency: _____
_____

Report Number: _____

WITNESSES

List the Name, Address, Driver's License/ID Card Number and Phone Number of each witness.

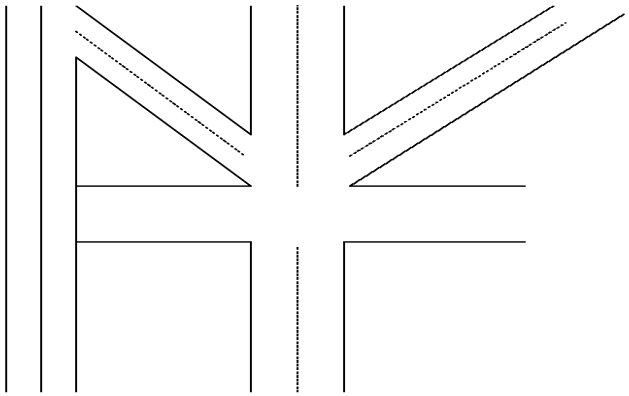
1. _____
_____
2. _____
_____
3. _____
_____

DESCRIPTION OF COLLISION

Your speed (in miles per hour): _____

Details: _____
_____
_____
_____

DIAGRAM



Damage to City vehicle: _____
_____
_____