

**AUTO COLLISION INFORMATION FORM
TEXAS TECH UNIVERSITY SYSTEM**

If you have a collision, use this form to record the facts about the collision, including names and address of all parties involved, and any witnesses to the collision. Give the completed form to your Department head. The Department head will send the form to Office of Risk Management PO Box 42003 (MS 2003) Lubbock, Texas 79409

Date of collision and time AM PM Location of Collision (Include City & State)

Description of Collision (use reverse side if necessary)

Authority Contacted and Report #

Any violations/citations as a result of the collision (describe)

PROPERTY DAMAGED (NOT YOUR VEHICLE)

Describe Property
(If auto, year, make,
model, plate #)
Owner's
Name &
Address

Insurance Company

Other Driver's
Name & Address
(Check if
same as owner)

Residence Phone
(A/C, No. Ext):
Business Phone
(A/C, No. Ext):
Residence Phone
(A/C, No. Ext):
Business Phone
(A/C, No. Ext):

Driver's License Number

Describe Damage

Where can damage be seen?

Insurance Company Name

Policy Number

Agent's Name and Number

INJURED PARTIES

Name & Address

Phone (A/C, No) Age Describe Injury

Injured was: Pedestrian In your car In other car

Injured was: Pedestrian In your car In other car

WITNESSES OR PASSENGERS

Name & Address

Phone (A/C, No.) Ins Veh Oth Veh Statement Attached?

YOUR INSURED VEHICLE

Year Make Model VIN Inventory #

Department Name

Department Phone

Supervisor you reported this to:

(A/C, No)

Department Head Name

Driver's Name
& Address

Residence Phone
(A/C, No.)
Business Phone
(A/C, No. Ext):

Relation to Insured
(Employee, family, etc.)

Date of Birth

Driver's License #

State

Purpose
of Use

Used with Permission
Yes No

Describe

Where can

When can Vehicle

Damage

Vehicle be seen?

be seen?

In addition to this form please provide a copy of the police report and OP 76.34 attachments B & C. In the event of collision