



Revised July, 2023

**TO:** All ANR Drivers

**FROM:** Brian Oatman, ANR Risk & Safety Services

**RE:** ANR Vehicles – Insurance, Incident Reporting, Emergency Services

This letter is to inform UC ANR employees of the procedures they should follow in the event of an accident or urgent maintenance need 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/supplements 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 provides 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 University insurance programs this can be found at <http://ucanr.edu/risk>. Supplement A of this document is a copy of the Certificate of Self-Insurance, and includes the address for ANR Risk & Safety Services, where claims can be sent.

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

Enterprise Risk Management Program  
Phone: (800) 325-8838  
Policy: LAAUT0007100

**Accident/Incident Reports:**

In the event of an accident, first ensure that everyone involved is safe and receiving the appropriate medical attention as 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 a police report is made, please provide the report number, officer name/badge number, and law enforcement agency. If possible take pictures or video (such as from a cell phone) of the surrounding area, vehicle(s), and property involved in the accident and any observed damage. A diagram of the scene can also be provided to help

explain the accident (Supplement C). Please send any incident reports, attachments, and/or photos/videos to Risk & Safety Services: care of Linda Harris or Brian Oatman ([olharris@ucanr.edu](mailto:olharris@ucanr.edu) or [baotman@ucanr.edu](mailto:baotman@ucanr.edu)).

If an ANR employee is injured in the accident, fill out the UCD Employer's Report of Occupational Injury or Illness (Supplement D) and submit this form to ANR Staff Personnel Unit ([anrstaffpersonnel@ucanr.edu](mailto:anrstaffpersonnel@ucanr.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 an estimated value more than \$750, **or**
- Anyone was injured (no matter how minor), **or**
- A fatality occurred.

**NOTE:** ANR drivers of a **UC-owned vehicles** (ANR vehicles & those rented from a UC campus) 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 ANR Risk & Safety Services at (530) 750-1263 or emailed to: [olharris@ucanr.edu](mailto:olharris@ucanr.edu) or [baotman@ucanr.edu](mailto:baotman@ucanr.edu).

As applicable, each driver of a **personal, leased, or rented car** involved in an accident meeting the criteria defined above 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@ucanr.edu](mailto:olharris@ucanr.edu) or [baotman@ucanr.edu](mailto:baotman@ucanr.edu).

### **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.edu/Programs/Driver\\_Safety/](http://safety.ucanr.edu/Programs/Driver_Safety/)

### **Fuel, Urgent Repair, & Emergency Services:**

The following services can be obtained depending on the vehicle (see table on next page):

## Fuel, Urgent Repairs, and Emergency Roadside Services

Service	UC Vehicles	Enterprise Leased Vehicles
<b>Fuel</b>	<ul style="list-style-type: none"> <li>Use WEX card (if provided with vehicle) at most gas stations that accept credit cards.</li> </ul>	<ul style="list-style-type: none"> <li>Use WEX card (if provided with vehicle) at most gas stations that accept credit cards.</li> </ul>
<b>Urgent Repair &amp; Services</b>	<ul style="list-style-type: none"> <li>WEX card may be used to pay for emergency repairs up to \$500.</li> <li>For WEX card service purchases over \$500, contact Risk &amp; Safety Services for approval.                             <ul style="list-style-type: none"> <li>Brian Oatman (530) 304-2054</li> </ul> </li> <li>The WEX card may be used at many vendors including: Big O Tires, Goodyear, Jiffy Lube, Les Schwab, MIDAS, Safelite Auto Glass, etc.</li> <li>To find WEX card approved maintenance or fuel locations, visit <a href="https://go.wexonline.com/external/accepting-locations">https://go.wexonline.com/external/accepting-locations</a></li> <li>For WEX card assistance or issues, call 1-833-225-5939</li> </ul>	<ul style="list-style-type: none"> <li>Contact Enterprise National Service Department (NSD) for an authorized repair location prior to receiving service. Phone # (800) 325-8838</li> <li>Use the Enterprise Full Maintenance card (provided with vehicle) to pay for service.</li> </ul>
<b>Emergency Roadside Services</b>	<ul style="list-style-type: none"> <li>Contact WEX Roadside Assistance</li> <li>Phone # 1-866-329-3471</li> <li>Use WEX card to pay for service.</li> </ul>	<ul style="list-style-type: none"> <li>Contact Enterprise NSD Phone # (800) 325-8838</li> <li>Use the Enterprise Full Maintenance card (provided with vehicle) to pay for service.</li> </ul>

**Attachments:**

- 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

# CERTIFICATE OF SELF-INSURANCE COVERAGE

Date: **June 15, 2023**

**PRODUCER/INSURED**

The Regents of the University of California  
Office of the President  
Office of Risk Services  
1111 Franklin St., 10<sup>th</sup> Floor  
Oakland, CA 94607-5200  
510-987-9832

This Certificate is issued as a matter of information only to authorized viewers for their internal use only and confers no rights upon any viewer of this Certificate. The Certificate does not amend, extend or alter the coverage described below. This Certificate may only be copied, printed and distributed by an authorized viewer for its internal use. Any other use, duplication or distribution of the Certificate without the written consent of the Regents of the University of California is prohibited.

### ENTITIES AFFORDING COVERAGE

	<b>PARTICIPATION</b>
COMPANY LETTER A <b>The Regents of the University of California</b>	<b>100 %</b>

**COVERAGES**

THIS IS TO CERTIFY THAT THE REGENTS OF THE UNIVERSITY OF CALIFORNIA IS A GOVERNMENTAL ENTITY THAT HAS A SELF-FUNDED RETENTION FOR LIABILITIES DESCRIBED BELOW, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY WRITTEN CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY PERTAIN. THIS SELF-FUNDED PROGRAM IS SUBJECT TO ALL PROVISIONS OF THE BYLAWS AND STANDING ORDERS OF THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, WHICH DOES NOT PERMIT ANY ASSUMPTION OF LIABILITY WHICH DOES NOT RESULT FROM THE NEGLIGENT ACTS OR OMISSIONS OF ITS OFFICERS, AGENTS OR EMPLOYEES.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS
A	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCURRENCE	Self-Insured	July 1, 2023	July 1, 2024	GENERAL AGGREGATE \$ Not applicable PRODUCTS-COMP/OP AGG \$ 5,000,000 PERSONAL & ADV INJURY \$ 5,000,000 CONTRACTUAL LIABILITY \$ 5,000,000 EACH OCCURRENCE \$ 5,000,000 \$
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS <input type="checkbox"/> GARAGE LIABILITY	Self-Insured	July 1, 2023	July 1, 2024	COMBINED SINGLE LIMIT \$ Not applicable  BODILY INJURY (PER PERSON) \$ 2,500,000  BODILY INJURY (PER ACCIDENT) \$ 2,500,000  PROPERTY DAMAGE \$ 2,500,000
A	<b>PROPERTY</b> <input checked="" type="checkbox"/> FIRE & EXTENDED PERILS	Self-Insured	July 1, 2023	July 1, 2024	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ Not applicable \$
A	<b>WORKERS' COMPENSATION AND EMPLOYERS LIABILITY</b>	Self-Insured	July 1, 2023	July 1, 2024	STATUTORY LIMITS EACH ACCIDENT \$ As required by California Law DISEASE - POLICY LIMIT \$ As required by California Law DISEASE - EACH EMPLOYEE \$ As required by California Law

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

**ADDITIONAL COVERED PARTY- AS REQUIRED BY WRITTEN CONTRACT OR AGREEMENT WITH RESPECT TO GENERAL LIABILITY AND AUTOMOBILE LIABILITY**

**LOSS PAYEE - AS REQUIRED BY WRITTEN CONTRACT OR AGREEMENT WITH RESPECT TO PROPERTY COVERAGE**

**CERTIFICATE HOLDER  
APPLICABLE PARTY AS REQUIRED BY WRITTEN CONTRACT OR AGREEMENT**

**CANCELLATION**

SHOULD THE REGENTS ELECT TO DISCONTINUE SELF-INSURING ITS LIABILITIES, THE REGENTS WILL UPDATE PROOF OF SELF-INSURANCE ON ITS WEBSITE. THE REGENTS SHALL NOT BE OBLIGATED TO PROVIDE INDIVIDUAL NOTICE TO VENDORS OR OTHERS.

By:



KEVIN CONFETTI, AVP & CHIEF RISK OFFICER

**TO: DRIVERS OF ANR UNIVERSITY OF CALIFORNIA VEHICLES**

RE: (1) Evidence of Financial Responsibility  
(2) Department of Motor Vehicles (DMV) Financial Responsibility Form SR-1

(1)

Under California Vehicle Code Section 16020, Paragraph (b), the University of California is exempt from carrying evidence of financial responsibility for vehicles it owns.

If you receive a request for evidence of financial responsibility, please respond that the University of California is a public entity and is self-insured. However as a courtesy, you may provide a copy of the attached ANR Certificate of Self-Insurance.

Additionally, if you are involved in an accident please complete the attached Incident Report with basic information within 48 hours or as soon as practical and submit it to your immediate supervisor. You may attach additional sheets as necessary to describe the incident. Retain a copy for your records and either you or your supervisor will forward the Report to the Office of Risk Services.

Any inquiries may be directed to the Office of Risk Services at (530) 750-1263, or mailed to:

University of California  
Agriculture & Natural Resources  
Office of Risk Services  
2801 Second Street  
Davis, CA 95618-7774

(2)

Under California Vehicle Code Section 16000, Paragraph (b), the University of California is exempt from filing DMV Financial Responsibility Form SR-1.

If you receive a request 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 Office of Risk Services at (530) 750-1263 or mailed to:

University of California  
Agriculture & Natural Resources  
Office of Risk Services  
2801 Second Street  
Davis, CA 95618-7774

ANR Office of Risk Services



# INCIDENT REPORT

Use this form to document vehicle accidents, theft, property damage or loss. This form should also be used to report injuries to ANR volunteers, 4-H members, program participants, or visitors. This form should not be used to report employee work-related injuries (i.e. Workers' Compensation). Employees should promptly report all injuries or illnesses to their supervisor.

Please submit this form within 48 hours of incident

Date/Time of Incident: \_\_\_\_\_  AM  PM Date/Time Incident Report Completed: \_\_\_\_\_  AM  PM

### Injured/Damaged 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

### Injured/Damaged 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

### Injured/Damaged 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: \_\_\_\_\_

Use this section if more than one party

Use this section if more than two parties

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.



## INCIDENT REPORT

Use this form to document vehicle accidents, theft, property damage or loss. This form should also be used to report injuries to ANR volunteers, 4-H members, program participants, or visitors. This form should not be used to report employee work-related injuries (i.e. Workers' Compensation). Employees should promptly report all injuries or illnesses to their supervisor.

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

Nature of Injury, property damage or loss (list parts of body and type of injury, i.e., sprained right ankle or specify damage):

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) 750-1263.

### *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, property damage, theft, or other losses, including motor vehicle accidents. The form should also be used to report injuries to non-employees (i.e.: volunteers, youth members, visitors) participating in UC ANR activities or events. Employee injuries must be reported using the process and forms described at [http://safety.ucanr.edu/Guidelines/Reporting\\_an\\_Injury/](http://safety.ucanr.edu/Guidelines/Reporting_an_Injury/).

### *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 (volunteers should report to a UC ANR staff member) as soon as practical. If they are not available call the Risk Services Office at (530) 750-1263.

### *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. Volunteers at Research & Extension Centers (RECs) should submit the form to the REC office.

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

ANR Risk Services  
2801 Second St.  
Davis, CA 95618-7774

Telephone: (530) 750-1263  
Fax: (530) 756-1113  
e-mail: [olharris@ucanr.edu](mailto:olharris@ucanr.edu)

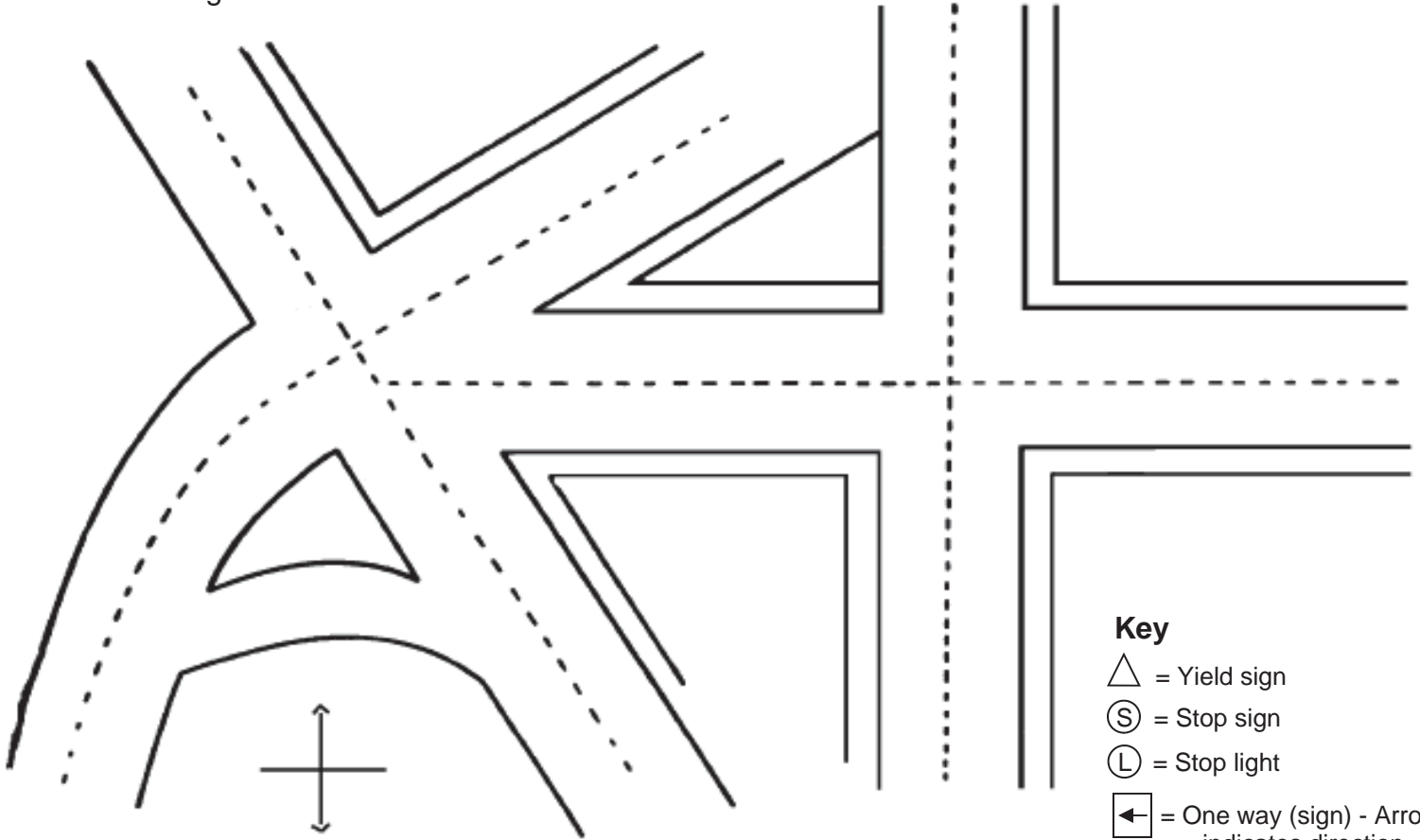
### *Where do I obtain a copy of the Incident Report form?*

You may obtain copies of the Incident Report form from any CE County Office or on the internet at: <http://ucanr.edu/risk>

**Note:** 4-H members, 4-H adult volunteers, Master Gardener, or Master Food Preserver volunteers may be eligible for "Accident and Sickness" Coverage through an Accident Insurance Program policy with The 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.



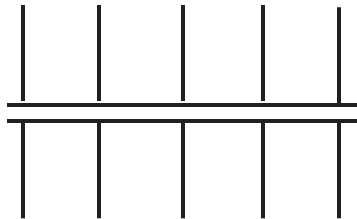
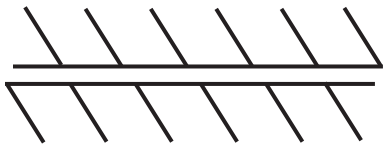
# Accident Diagram



## 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 _____ _____ _____ _____ _____	<b>Equipment</b> <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job <b>Personal protective equipment</b> <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 <b>Training/Experience</b> <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 <b>Work Area</b> <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)  <b>Ventilation issues</b> <input type="checkbox"/> Ergonomic factors <b>Employee</b> <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 <b>Assistance</b> <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"/> <b>Lack of policy/procedure</b> <input type="checkbox"/> <b>Animal</b> (explain below) _____ <input type="checkbox"/> <b>Other</b> (explain) _____ _____ _____ _____ <b>Use additional pages as needed</b>	<b>SUPERVISOR WILL:</b> <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 _____ _____ <b>Preventive actions will be completed by:</b> 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**

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

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

<b>DATE</b>	<b>PRINTED NAME</b>	<b>SIGNATURE</b> <b>X</b>
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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**.

<b>I N S U R A N C E</b>	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) <b>(CALIFORNIA ONLY)</b>			
	VEHICLE (YEAR AND MAKE)		VEHICLE IDENTIFICATION NUMBER	VEHICLE LICENSE PLATE NUMBER	STATE
	DRIVER		ADDRESS		
	OWNER		ADDRESS		
	FULL NAME OF POLICY HOLDER		ADDRESS		

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**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

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