

VEHICLE ACCIDENT FORM INSTRUCTIONS

Keep a Copy of Form in Dashboard of Vehicles

In case of a vehicle accident involving possible injury to any person, possible damage to another vehicle, or damage to any Archdiocese or non-Archdiocese property, please follow these steps.

1. Stop immediately and take precautions to prevent further collision, damage, or injury. a. If your vehicle is in the roadway, move to the side of the road out of traffic if it is safe to do it. If the vehicle not working, or you are injured, stay where you are.
2. Call 911 after any accident where there is possible injury to yourself or others, you feel that the scene is unsafe or it requires assistance to clear, or if you don't know what to do.
3. Collect and record information about the accident, the vehicles, and the people involved. Washington State Law requires the exchange of names, addresses, insurance companies, insurance policy numbers, and vehicle license numbers.
 - a. Use the following Vehicle Accident Form to help write this down.
4. Use your cellphone to take photographs or videos of damage to vehicles and other things related to the accident if it is safe to do so.
5. Never admit fault, do not apologize or say sorry (this can be interpreted as an admission of fault), and do not accept or offer settlements at the scene of an accident.
6. Do not discuss the accident with anyone except Emergency Response Personnel (police, fire, medical), Archdiocese or Parish Staff, or representatives of Sedgwick.
7. Report the incident to Sedgwick, our Administrator for Insurance Claims. Be prepared to provide them with the information you collected using the following form. a. **Call Sedgwick by phone at 866-471-9518**
8. Notify your supervisor of the incident when it is safe to do so and provide them with your completed Vehicle Accident Form for recordkeeping.
9. For collisions with \$1,000 or more in damage, you may need to file a [Motor Vehicle Collision Report](#) with Washington State Patrol. The only exception is if a police officer is present at the scene of the accident and states that they will submit the collision report.

Last Revised September 2025

VEHICLE ACCIDENT FORM

AUTO INSURANCE POLICY # **822500-0785428** (Active July 1, 2025 to June 30, 2026)

If an accident occurs, our Self Insurer Number (**SI-52**) should also be provided.

Vehicle Year, Make, and Model:
Vehicle ID (if

Parish Name & City: Parish ID (if known): known): VIN:
Vehicle belongs to:

DATE OF COLLISION			DAY OF COLLISION							TIME OF COLLISION			INVESTIGATED BY:		
MM	DD	YYYY	SUN	MON	TUE	WED	THU	FRI	SAT	HOURL	MINUTE		<input type="checkbox"/>	STATE PATROL	
						<input type="checkbox"/>						<input type="checkbox"/>	AM	<input type="checkbox"/>	CITY POLICE
														<input type="checkbox"/>	SHERIFF
													PM	<input type="checkbox"/>	OTHER POLICE
														<input type="checkbox"/>	NOT DONE
COLLISION INVOLVED		<input type="checkbox"/>	VEHICLE FIRE	<input type="checkbox"/>	HIT & RUN	<input type="checkbox"/>	STOLEN VEHICLE	TOTAL # UNITS (Vehicle, Pedestrian, Property Owner)				TOTAL # INJURIES		TOTAL # DEATHS	

ROAD SURFACE				WEATHER				LIGHT CONDITIONS				DISTRACTED DRIVER?			
<input type="checkbox"/>	DRY	<input type="checkbox"/>	SAND/MUD	<input type="checkbox"/>	CLEAR	<input type="checkbox"/>	FOG	<input type="checkbox"/>	DAYLIGHT	<input type="checkbox"/>	DARK – STREET LIGHTS ON	UNIT #		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	WET	<input type="checkbox"/>	OIL	<input type="checkbox"/>	OVERCAST	<input type="checkbox"/>	SLEET	<input type="checkbox"/>	DAWN	<input type="checkbox"/>	DARK – STREET LIGHTS OFF	UNIT #		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	SNOW	<input type="checkbox"/>	WATER	<input type="checkbox"/>	RAINING	<input type="checkbox"/>	WINDY	<input type="checkbox"/>	DUSK	<input type="checkbox"/>	DARK – NO STREET LIGHTS	UNIT #		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	ICE	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	SNOWING	<input type="checkbox"/>	OTHER			<input type="checkbox"/>	OTHER	UNIT #		<input type="checkbox"/> YES	<input type="checkbox"/> NO

LOCATION WHERE COLLISION OCCURED				
NAME OF STREET/HIGHWAY YOU WERE ON OR ADDRESS/NAME OF PARKING LOT OR BUILDING				
NEAREST STREET OR LANDMARK (Bridge, RR Crossing, Other)				
DISTANCE FROM LANDMARK		.	<input type="checkbox"/> IN FEET	<input type="checkbox"/> IN MILES
		<input type="checkbox"/> N <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> W		

DESCRIBE WHAT HAPPENED BELOW (REFER TO VEHICLES / INDIVIDUALS BY UNIT NUMBERS)

DIAGRAM --- INDICATE ON THIS DIAGRAM WHAT HAPPENED
SHOW NORTH BY ARROW

AT MOMENT OF
1. MAKE A DRAWING THAT SHOWS YOUR
COLLISION UNIT # _____ ACCIDENT _____ IN CIRCLE

☐ PARKED
UNOCCUPIED

☐ PARKED OCCUPIED
2. NUMBER EACH UNIT
☐ STOPPED ☐ MOVING

AND SHOW ITS
DIRECTION OF TRAVEL
BY ARROW
1 2

AT MOMENT OF
COLLISION UNIT # _____ Street or Highway _____

☐ PARKED ☐ PARKED
UNOCCUPIED OCCUPIED
☐ STOPPED ☐ MOVING

Street or
Highway

Last Revised – September 2025

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DRIVER and AOS UNITS INVOLVED

UNIT # _____	(MARK ONLY ONE)	<input type="checkbox"/> MOTOR VEHICLE	<input type="checkbox"/> PEDAL / CYCLE	<input type="checkbox"/> PEDESTRIAN	<input type="checkbox"/> PROPERTY OWNER	HELMET USED BY CYCLIST, SKATER/BOARDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME						NATURE OF INJURIES
FIRST NAME				MIDDLE INITIAL		
ADDRESS						
CITY		STATE		ZIP		
DRIVERS LICENSE #		STATE		DOB		
LICENSE PLATE #		STATE		VIN		<input type="checkbox"/> Check if Commercial Vehicle
						VEHICLE

VEHICLE YEAR		VEHICLE MAKE		VEHICLE MODEL / STYLE		(SHADE IN DAMAGED AREAS) Top Bottom
REGISTERED OWNER NAME				OWNER ADDRESS		
AUTO INSURANCE ACTIVE AT TIME OF COLLISION?		<input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY AND POLICY #			

UNIT # ____	(MARK ONLY ONE)	<input type="checkbox"/> MOTOR VEHICLE	<input type="checkbox"/> PEDAL / CYCLE	<input type="checkbox"/> PEDESTRIAN	<input type="checkbox"/> PROPERTY OWNER	HELMET USED BY CYCLIST, SKATER/BOARDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME						NATURE OF INJURIES
FIRST NAME				MIDDLE INITIAL		
ADDRESS						
CITY		STATE		ZIP		
DRIVERS LICENSE #		STATE		DOB		
LICENSE PLATE #		STATE		VIN		<input type="checkbox"/> Check if Commercial Vehicle
VEHICLE YEAR		VEHICLE MAKE		VEHICLE MODEL / STYLE		VEHICLE (SHADE IN DAMAGED AREAS) Top Bottom
REGISTERED OWNER NAME				OWNER ADDRESS		
AUTO INSURANCE ACTIVE AT TIME OF COLLISION?		<input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY AND POLICY #			

PASSENGERS

LAST NAME		IN UNIT #
FIRST NAME		MIDDLE INITIAL
ADDRESS		DATE OF BIRTH
NATURE OF INJURIES		

LAST NAME		IN UNIT #
FIRST NAME		MIDDLE INITIAL

ADDRESS		DATE OF BIRTH
NATURE OF INJURIES		

LAST NAME		IN UNIT #
FIRST NAME		MIDDLE INITIAL
ADDRESS		DATE OF BIRTH
NATURE OF INJURIES		