Vehicle Accident Procedures
Office of Institutional Compliance & Risk Management

These procedures provide guidance for Vehicle Operators involved in Vehicle accidents while in the scope of conducting University Business. Department heads/supervisors should ensure that their personnel are aware of and adhere to the guidelines herein.

ACU Vehicle Accident Reporting procedures, Accident Forms, and auto proof of insurance cards will be maintained in all university-owned and leased vehicles.

All vehicle accidents must be reported to the Office of ICRM at 325-674-6142 as soon as possible, but not to exceed 24 hours. In the event of a serious injury or fatality, the vehicle operator will notify the Office of ICRM as soon as possible. If the accident occurs outside of normal business hours, the Vehicle Operator will notify ACU Police at 325-674-2911.

In the event of an accident, the Vehicle Operator will complete the following:

A. PRIMARY ACTIONS

1. Immediately **call 9-1-1** to request applicable response (EMT, fire department, police)
2. Attempt to determine the status of injured and provide assistance
3. Do **not** move person(s) unless it is life threatening
4. Do **not** move vehicle(s) unless it is more dangerous to leave it where it is or if directed by fire department or law enforcement personnel to do so

B. SECONDARY ACTIONS

1. Notify ACU Police 325-674-2911 & the Office of ICRM 325-674-6142
2. Obtain the necessary information and fill out the Vehicle Accident Report, Attachment 2
3. Express **no** opinion as to who was at fault
4. Give no information except as requested by law enforcement officers
5. Do **not** sign a statement for anyone except a law enforcement officer

Please contact the Office of ICRM at 325-674-6142 or risk@acu.edu if you have any questions concerning these procedures.

Vehicle Accident Report

Return Form to:
Office of Institutional Compliance & Risk Management
Office: 325-674-6142 / Email: risk@acu.edu

ACU DRIVER'S INFORMATION

Driver's Name:_____ Phone #_____ DL # _____
Department Name:_____ Supervisor's Name: _____
Vehicle Make/Model:_____ Color:_____ License Plate # _____
Insurance Company:_____ Policy #_____ Phone # _____

OTHER VEHICLE INFORMATION

Driver #1 Name:_____ Phone #_____ DL # _____
Vehicle Make/Model:_____ Color:_____ License Plate # _____
Insurance Company:_____ Policy #_____ Phone # _____

Driver #2 Name:_____ Phone #_____ DL # _____
Vehicle Make/Model:_____ Color:_____ License Plate # _____
Insurance Company:_____ Policy #_____ Phone # _____

ACCIDENT INFORMATION

Date:_____ Time: _____ Police Report: Yes ◯ No ◯

Photos Taken: Yes ◯ No ◯ Taken by: (name/phone #) _____
Street Address/Location:_____ City:_____ State: _____

Describe what happened: _____

_____

_____

Describe other property damaged: _____

_____

MEDICAL INFORMATION

Persons injured? Yes ◯ No ◯ (If Yes, complete an Accident/Injury Report) 911 Called: Yes ◯ No ◯

Notify the Office of ICRM in the event of a serious injury

WITNESS INFORMATION

Witness #1 Name: _____ Phone # _____
Witness #2 Name: _____ Phone # _____

Completed by:_____ **Date**: _____