Auto accident report

To report an accident, please complete the form and send to Brandon Rothkopf, [brandonrothkopf@archstl.org](mailto:brandonrothkopf@archstl.org), 314-792-7079 (fax)

***Note: Any question with an asterisk (\*) is required information.***

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| **Client Information** | | | | | | | | | | | | | |
| \*GB Client Number | | 000292 | | | | | | | | | | | |
| \*Client Name | | Archdiocese of St. Louis | | | | | | | | | | | |
| **Date and Time** | | | | | | | | | | | | | |
| \*Incident Date | | Enter date. | | | | | Incident Time | | | | | Enter Time. | |
| \*Insured Notified Date | | Enter date. | | | | | | | | | | | |
| **Client Location** | | | | | | | | | | | | | |
| \*Location Code | | Enter Location Code. | | | | | | | | | | | |
| \*Name | | Enter Name. | | | | | | | | | | | |
| Street Address | | Enter Street Address. | | | | | | | | | | | |
| City | Enter City. | | | | \*State | Choose State. | | | | | ZIP | Enter ZIP. | |
| Phone Number | Enter phone #. | | | | | | | | |  | | | |
| **Submitter Information** | | | | | | | | | | | | | |
| Name | | Enter Name. | | | | | | | | | | | |
| Title | | Enter Title. | | | | | | | | | | | |
| Email Address | | Enter Email. | | | | | | | | | | | |
| Phone Number | | Enter Phone #. | | | | | | | | | | | |
| **Incident Information** | | | | | | | | | | | | | |
| \*Detailed Description of Incident, including any injuries (limit the characters to 250) | | Enter Description. | | | | | | | | | | | |
| **Witnesses** *(Only if any Witnesses)* | | | | | | | | | | |  | | |
| First Name | | Enter First Name. | | | | | | Last Name | | | | Enter Last Name. | |
| Home Phone | | Enter Phone #. | | | | | | Work Phone | | | | Enter Phone #. | |
| **Location of Incident** *(type SAME, if same as reporting location)* | | | | | | | | | | | | | |
| Location Name | | Enter Location Name. | | | | | | | | | | | |
| Street Address | | Enter Street Address. | | | | | | | | | | | |
| City | Enter City. | \*State | | Choose State. | | | | | ZIP | | | Enter ZIP. | |
| **Authority** | | |
| Authority Name (e.g. police officer) | | Enter Name. | | | | | | | | | | | |
| Phone Number | | Enter Phone #. | | | | | | | | | | | |
| Report Number | | Enter Report #. | | | | | | | | | | | |
| **Involved Parties** *(can add as many as necessary)* | | | | | | | | | | | | | |
| SSN | | Enter SSN. | | | | | | | | | | | |
| \*First Name | | Enter Name. | | | | | Middle Initial | | | | | | Enter Initial. |
| \*Last Name | | Enter Name. | | | | |  | | | | | | |
| Home Phone | | Enter Phone #. | | | | | Work Phone/Ext. | | | | | | Enter Phone #/Ext. |
| Street Address | | Enter Street Address. | | | | | | | | | | | |
| City | Enter City. | State | | Choose State. | | | ZIP | | | | | | Enter ZIP. |
| Birth Date | Enter date. | Date of Death (if applicable) | | | | | Enter date. | | | | | | |
| Marital Status | Choose... | Gender | | Choose... | | | | | | | | | |
| Driver’s License Number | | Enter #. | | | | | | | | | | | |
| State | | Choose State. | | | | | | | | | | | |
| Citation Type | | Enter text. | | | | | | | | | | | |
| \*Relationship to Client (employee, spouse, self, customer, unknown, other) | | Enter text. | | | | | | | | | | | |
| **Injured Party** | |  | | | | | | | | | | | |
| Injured Party Involvement (Insured vehicle driver, Insured vehicle passenger, other vehicle driver, other vehicle passenger, pedestrian) | | Enter text. | | | | | | | | | | | |
| First Name | | Enter Name. | | | | | Middle Initial | | | | | | Enter Initial. |
| Last Name | | Enter Name. | | | | | Age | | | | | | Enter Age. |
| Extent of Injury | | Enter text. | | | | | | | | | | | |
| Street Address | | Enter Street Address. | | | | | | | | | | | |
| City | Enter City. | State | | Choose State. | | | ZIP | | | | | | Enter ZIP. |
| Phone | Enter Phone #. | | | | | | | | | | | | |

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| **Medical Provider** *(Only if medical treatment rendered for an Injured Party)* | | | | | | | | |
| Hospital/Clinic Name | | | Enter text. | | | | | |
| Street Address | | | Enter Street Address. | | | | | |
| City | Enter City. | | State | Choose State. | | ZIP | | Enter ZIP. |
| Phone Number | | Enter Phone #. | | | | | | |
| Doctor Name | | Enter Name. | | | | | | |
| Street Address | | Enter Street Address. | | | | | | |
| City | Enter City. | | State | Choose State. | | ZIP | | Enter ZIP. |
| Phone Number | | Enter Phone #. | | | | | | |
| **Vehicle** *(can be as many as necessary)* | | | | | | | | |
| Third Party Vehicle? | | Choose... | | | Veh/Asset/Fleet Number | | Enter #. | |
| VIN | | Enter #. | | | Vehicle Type | | Enter text. | |
| Body Type | | Enter text. | | | Year | | Enter text. | |
| Make | | Enter text. | | | Model | | Enter text. | |
| Color | | Enter text. | | | Plate # | | Enter text. | |
| Plate State | | Choose State. | | |  | |  | |
| Damage Description | | Enter text. | | | | | | |
| Estimated Damage | | Enter text. | | | | | | |
| Insurance Company | | Enter text. | | | | | | |
| Policy Number | | Enter text. | | | | | | |
| **When/Where Can Be Seen** *(current location of vehicle)* | | | | | | | | |
| Name | | | Enter Name. | | | | | |
| Street Address | | | Enter Street Address. | | | | | |
| City | Enter City. | | State | Choose State. | | ZIP | | Enter ZIP. |
| County | Enter text. | | | | | When | | Enter text. |
| Owner | Enter text. | | | | | | | |
| **Property** *(if applicable)* | | | | | | | | |
| Third Party Property? | | Choose... | | | | | | |
| Describe Item(s) | | Enter text. | | | | | | |
| Damage Description | | Enter text. | | | | | | |
| Estimated Damage | | Enter text. | | | | | | |
| Insurance Co. Name | | Enter text. | | | | | | |
| Policy Number | | Enter text. | | | | | | |

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| **When/Where Can Be Seen** *(current location of vehicle)* | | | | | | | |
| Name | | | Enter Name. | | | | |
| Street Address | | | Enter Street Address. | | | | |
| City | Enter City. | | State | Choose State. | ZIP | | Enter ZIP. |
| When | Enter text. | | | | | | |
| Owner | | Enter Owner Name. | | | | | |
| **Notes/Additional Comments** *(ie, if this is for report only)* | | | | | | | |
| Additional Remarks | | Enter text. | | | | | |
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| NOTE: If employee was injured, please advise if a Work Comp claim should be entered as well. | | | | | | Choose... | |
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