

IF YOU HAVE AN AUTO INCIDENT

1. STOP IMMEDIATELY

Take all necessary precautions to prevent further incidents at the scene

2. CALL OR SEND FOR HELP – DO NOT LEAVE THE SCENE

Emergency –

- Call 911 (off-campus) / JMU Police - 540-568-6911

Non-Emergency –

- JMU Police (on-campus/in Harrisonburg City limits)- 540-568-6911
- Virginia State Police (off-campus)- 804-674-2000
- OR, local police if the accident occurs outside of Virginia

3. ON THE SCENE

- Collect Reporting Officer's contact information (If no officer is being sent to the scene, collect dispatch personnel information)
- Collect Witness' contact information
- Take Photos of all four (4) corners/sides of the car; both near and far. The more photos the better.

DO NOT make a statement to anyone other than Risk Management, the Police, or the Commonwealth of Virginia representative assigned by the Division of Risk Management

4. REPORTING

- **Notify** your supervisor.
- **Notify** Risk Management and Transportation offices **within 24 hours** of accident.
Risk Management – 540-568-7215; riskmanagement@jmu.edu
Transportation – 540-568-8147
- **Complete** the Automobile Incident Report (AIR) form to be submitted to Risk Management **within 24 hours** of returning to campus.

If you have questions, please contact Risk Management at 540-568-7215



INFORMATION EXCHANGE	
Use this sheet to obtain key information from the other driver involved.	
NAME:	PHONE:
ADDRESS:	
NAME AND PHONE OF INSURANCE COMPANY:	
YEAR/MAKE OF VEHICLE:	ARE YOU THE OWNER? <input type="checkbox"/> YES <input type="checkbox"/> NO
	LICENSE NUMBER:
INJURED PASSANGERS/ADDRESSES:	
WITNESSES/ADDRESSES:	
Use Reverse Side If Necessary	

INFORMATION EXCHANGE	
Use this sheet to obtain key information from the other driver involved.	
NAME:	PHONE:
ADDRESS:	
NAME AND PHONE OF INSURANCE COMPANY:	
YEAR/MAKE OF VEHICLE:	ARE YOU THE OWNER? <input type="checkbox"/> YES <input type="checkbox"/> NO
	LICENSE NUMBER:
INJURED PASSANGERS/ADDRESSES:	
WITNESSES/ADDRESSES:	
Use Reverse Side If Necessary	



Commonwealth of Virginia Automobile Liability Inquiries

(For use when there is damage to a personally owned vehicle or other personal property.)

The Commonwealth of Virginia is self-insured. If you would like to assert a claim, you may submit your claim (along with all supporting documents and details of the incident) to:

Commonwealth of Virginia
Division of Risk Management
Post Office Box 1879
Richmond, VA 23218-1879
Phone: 866-857-6866

When phoning, please have the Driver Exchange information provided by the investigating officer.

Suggested documentation to include with your submission:

1. A letter stating your claim for damages as well as your contact information
2. A copy of the police report
3. Two estimates for damage repairs
4. Witness statements
5. Photos of damage

PROVIDE TO PARTIES INVOLVED IN INCIDENT

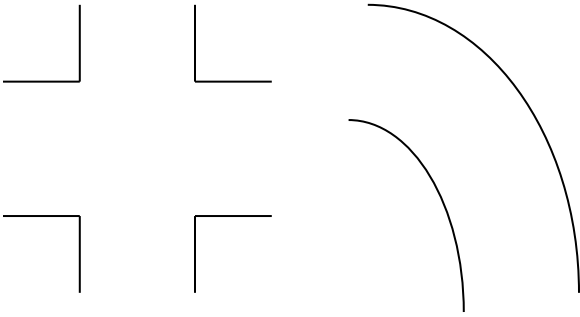
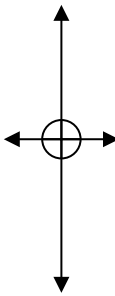
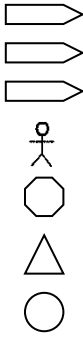
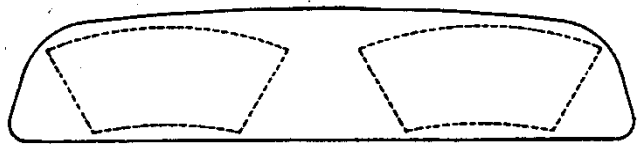
**COMMONWEALTH OF VIRGINIA - JAMES MADISON UNIVERSITY
AUTOMOBILE INCIDENT REPORT**

CONFIDENTIAL: CLAIM INVESTIGATIVE MATERIALS

Agency Driver: Complete this form and email it to riskmanagement@jmu.edu or send by fax: 540-568-2665
If available, include a copy of the police report
Do not discuss accident with anyone except Commonwealth of Virginia representative and police

Vehicle Pool Number

AGENCY NAME	NAME JAMES MADISON UNIVERSITY				PHONE NUMBER 540-568-7215		
	ADDRESS: STREET 800 S MAIN STREET		CITY HARRISONBURG	STATE VA	ZIP CODE 22807	FAX NUMBER 540-568-2665	
TIME AND PLACE OF INCIDENT	DATE OF INCIDENT	HOUR AM <input type="checkbox"/> PM <input type="checkbox"/>	LOCATION	STREET OR HIGHWAY	CITY	COUNTY STATE	
	MAKE OF AUTO	YEAR	MODEL	VEHICLE IDENTIFICATION NUMBER		LICENSE PLATE #	
ABOUT YOUR AUTO (#1)	NAME OF DRIVER			ADDRESS: STREET	CITY	STATE ZIP CODE	
	DRIVER'S PHONE NUMBER			DEPARTMENT & SUPERVISOR'S NAME & PHONE NUMBER			
	LICENSED DRIVER? YES <input type="checkbox"/> NO <input type="checkbox"/>	DRIVER'S LICENSE # & ISSUING STATE:		DRIVER'S DATE OF BIRTH:	DRIVER'S TITLE:		
	WHERE WERE YOU GOING AT TIME OF ACCIDENT? (Specify Location)						
	WHERE WERE YOU COMING FROM WHEN THE ACCIDENT HAPPENED? (Specify Location)						
	NAME OF OWNER OR LEASING AGENT:		WHO GAVE PERMISSION? NAME & TITLE		PURPOSE OF VEHICLE USE AT TIME OF INCIDENT: (Specify)		
	DESCRIBE PARTS DAMAGED AND EXTENT OF DAMAGE.						
	WHERE MAY AUTO BE SEEN?			ESTIMATED COST OF REPAIRS			
	OTHER AUTO (#2)	MAKE OF AUTO	YEAR	MODEL	LICENSE PLATE NUMBER	ESTIMATED COST OF REPAIRS	
		PARTS DAMAGED AND EXTENT OF DAMAGE					
OWNER'S NAME & PHONE NUMBER			ADDRESS: STREET	CITY	STATE ZIP CODE		
DRIVER'S NAME & PHONE NUMBER <input type="checkbox"/> SAME			ADDRESS: STREET	CITY	STATE ZIP CODE		
IS AUTO INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF INSURANCE COMPANY		POLICY NUMBER	INSURANCE COMPANY PHONE NUMBER		
PASSENGERS	NAMES OF PASSENGERS IN AUTO (#1)		INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	ADDRESSES: STREET CITY STATE ZIP CODE			
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				
	NAMES OF PASSENGERS IN AUTO (#2)		INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	ADDRESSES: STREET CITY STATE ZIP CODE			
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE				

WITNESS	NAMES	ADDRESSES: STREET CITY STATE ZIP CODE				PHONE NUMBER
	NAMES	ADDRESSES: STREET CITY STATE ZIP CODE				PHONE NUMBER
PROPERTY DAMAGE OTHER THAN AUTO	NAME OF OWNER	ADDRESSES: STREET CITY STATE ZIP CODE				
	DESCRIPTION OF DAMAGED PROPERTY					
	ESTIMATED COST OF REPAIR	WHERE MAY PROPERTY BE SEEN?				
DESC. OF INCIDENT	ON WHAT STREET WERE YOU DRIVING?	DIRECTION	SPEED	STREET OR ROAD OTHER AUTO WAS DRIVING ON?	DIRECTION	SPEED
	WERE YOUR LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM	WERE OTHER AUTO'S LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM		WHAT TRAFFIC CONTROLS?	FOR WHOM	SPEED LIMIT
	DID EITHER DRIVER GIVE SIGNAL OF ANY KIND? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHO?			IF INTERSECTION, WHO ENTERED FIRST?	WHO HAD RIGHT OF WAY?	
	DID POLICE INVESTIGATE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		POLICE AGENCY			
	POLICE OFFICER NAME AND/OR BADGE NUMBER			POLICE PHONE NUMBER		
	DESCRIBE IN YOUR OWN WORDS HOW INCIDENT HAPPENED:					
	SHOW ON THE DIAGRAM THE POSITIONS OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTHER OBJECTS. SHOW STREET NAMES					
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;">  </div> <div style="text-align: center;">  </div> <div style="text-align: right;">  <ul style="list-style-type: none"> #1 MY AUTO #2 OTHER AUTO THIRD AUTO PEDESTRIAN STOP SIGN YIELD SIGN STOP LIGHT </div> </div>						
GLASS BREAKAGE	LOCATION OF BREAKAGE: <input type="checkbox"/> DOOR <input type="checkbox"/> VENT <input type="checkbox"/> REAR <input type="checkbox"/> WINDSHIELD <input type="checkbox"/> OTHER – DESCRIBE					
	TYPE OF GLASS <input type="checkbox"/> TINTED <input type="checkbox"/> SAFETY PLATE <input type="checkbox"/> CLEAR <input type="checkbox"/> SAFETY PLATE	TYPE OF BREAK <input type="checkbox"/> CRACKED <input type="checkbox"/> SHATTERED		<input type="checkbox"/> BULL'S EYE (O)	<input type="checkbox"/> CHIPPED OR PITTED <input type="checkbox"/> HALF MOON ()	
	WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION ON DIAGRAM:					
						
DATE OF REPORT		REPORTED BY				
DATE SIGNED	DRIVER (PRINT NAME)	DRIVER (SIGNATURE)		DRIVER EMAIL		
DATE SIGNED	SUPERVISOR (PRINT NAME)	SUPERVISOR (SIGNATURE)		SUPERVISOR EMAIL		