

# UNIVERSITY OF WASHINGTON VEHICLE ACCIDENT CLAIM FORM

In order to file a claim, return completed form to: Claim Services  
 Box 354964  
 Seattle, WA 98195  
 (206) 543-3657 Fax: (206) 543-6744  
 Website: <http://risk.uw.edu/>

**In the event that the claim cannot be resolved informally, filing this claim with the University of Washington does not constitute a filing with the Department of Enterprise Services pursuant to RCW 4.92.110. Please note this Claim Form is subject to public disclosure, and may be disclosed without redaction.**

## CLAIMANT AND INCIDENT INFORMATION

CLAIMANT'S NAME (A separate form must be completed for each claimant)			DATE OF ACCIDENT		TIME <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
CURRENT ADDRESS (RESIDENCE)		CITY	STATE	ZIP	HOME PHONE: BUSINESS PHONE: EMAIL:	
CITY/STATE/COUNTY (if applicable) WHERE OCCURRED			STREET OR HWY.	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD	

## YOUR VEHICLE INFORMATION (VEHICLE #1)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN THE CAR BE SEEN?	WHEN?
NAME OF VEHICLE OWNER		ADDRESS	CITY	HOME AND WORK PHONE	
NAME OF DRIVER		ADDRESS	CITY	HOME AND WORK PHONE	
DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE	DATE OF EXPIRATION	
DESCRIBE DAMAGE			ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.	

## OTHER VEHICLE INFORMATION (VEHICLE #2)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?	WHEN?
NAME OF VEHICLE OWNER		ADDRESS	CITY	HOME AND WORK PHONE	
NAME OF DRIVER		ADDRESS	CITY	HOME AND WORK PHONE	
DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE	DATE OF EXPIRATION	
DESCRIBE DAMAGE					ESTIMATE \$

## OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? If so, describe what type of property was damaged.				
NAME OF OWNER		ADDRESS	CITY	PHONE
DESCRIBE DAMAGE				ESTIMATE \$

**COMPLETE ALL DETAILS**  
**INJURED PARTIES**

NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
		HOME WORK							
		HOME WORK							

**WITNESSES AND PERSONS WITH KNOWLEDGE OF LIABILITY OR DAMAGE FACTS**

NAME (Attach additional sheets if necessary)	ADDRESS	CITY	PHONE
			HOME WORK
			HOME WORK
			HOME WORK

DATE OF ACCIDENT			TIME	LOCATION (STREET)	OR NEAR INTERSECTION OF:
MO	DAY	YEAR			
			<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		

CITY AND STATE	TYPE:			
	<input type="checkbox"/> Front to rear	<input type="checkbox"/> Head-on	<input type="checkbox"/> Parked car	<input type="checkbox"/> Pedestrian
<input type="checkbox"/> Broadside	<input type="checkbox"/> Sideswipe	<input type="checkbox"/> Bike-car	<input type="checkbox"/> Hit object	

	#1 YOUR VEHICLE	#2 OTHER PARTY (NAME)	#3 OTHER PARTY (NAME)
1. If pedestrian, where was he (crosswalk, etc.?)			
2. At what distance was danger first noticed?			
3. Speeds at time danger was first noticed?			
4. Speeds at time of accident?			
5. What warning signals given?			
6. Obstruction to vision (weather and other)?			
7. Lights on? Wipers on? Windows fogged?			
8. Had any party been drinking? Who?			

**DESCRIPTION:** Please describe the accident in detail and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

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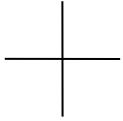
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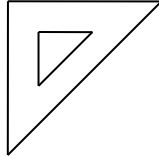
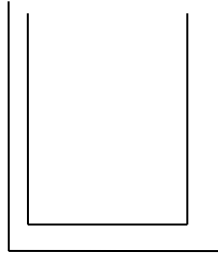
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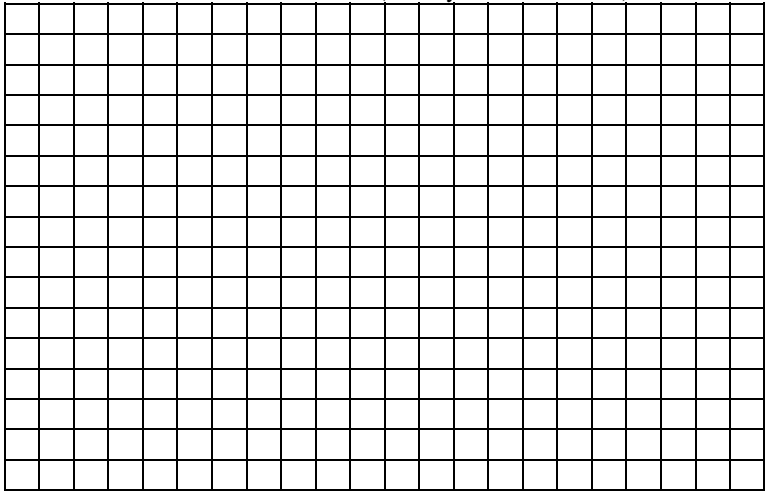
Indicate points of compass: N, E, S, W

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

**IMPORTANT:** If street or view was obstructed in any way, indicate where and how, also indicate any street, cars or tracks and traffic signal or signs. You may wish to draw a separate diagram on another piece of paper.



GRID DIAGRAM FOR YOUR USE (Show your vehicle as #1)



LIGHT CONDITIONS (check one)	TRAFFIC CONTROL	TYPE OF ROAD (check one or more)	VEHICLE CONDITION (check one or more)	ROAD SURFACE (check one)	WEATHER (check one)
1. <input type="checkbox"/> Daylight	#1 #2 VEHICLE	#1 #2 VEHICLE	#1 #2 VEHICLE	#1 #2 VEHICLE	1 <input type="checkbox"/> Clear, cloudy and overcast
2. <input type="checkbox"/> Dawn	<input type="checkbox"/> 1 <input type="checkbox"/> Signals	<input type="checkbox"/> 1 <input type="checkbox"/> One way	<input type="checkbox"/> 1 <input type="checkbox"/> Defective brakes	<input type="checkbox"/> 1 <input type="checkbox"/> Dry	2 <input type="checkbox"/> Raining
3. <input type="checkbox"/> Dusk	<input type="checkbox"/> 2 <input type="checkbox"/> Stop sign	<input type="checkbox"/> 2 <input type="checkbox"/> Two way	<input type="checkbox"/> 2 <input type="checkbox"/> Defective headlights	<input type="checkbox"/> 2 <input type="checkbox"/> Wet	3 <input type="checkbox"/> Snowing
4. <input type="checkbox"/> Dark, street lights on	<input type="checkbox"/> 3 <input type="checkbox"/> Flashing red	<input type="checkbox"/> 3 <input type="checkbox"/> Reversible road	<input type="checkbox"/> 3 <input type="checkbox"/> Defective rear lights	<input type="checkbox"/> 3 <input type="checkbox"/> Snow	4 <input type="checkbox"/> Fog
5. <input type="checkbox"/> Dark, street lights off	<input type="checkbox"/> 4 <input type="checkbox"/> Flashing amber	<input type="checkbox"/> 4 <input type="checkbox"/> Interchange loop ramp	<input type="checkbox"/> 4 <input type="checkbox"/> Tires worn	<input type="checkbox"/> 4 <input type="checkbox"/> Ice	5 <input type="checkbox"/> Other (specify)
6. <input type="checkbox"/> Dark, no street lights	<input type="checkbox"/> 5 <input type="checkbox"/> RR signal	<input type="checkbox"/> 5 <input type="checkbox"/> Alley	<input type="checkbox"/> 5 <input type="checkbox"/> Punctured or blown tires	<input type="checkbox"/> 5 <input type="checkbox"/> Other (specify)	
7. <input type="checkbox"/> Other (specify)	<input type="checkbox"/> 6 <input type="checkbox"/> Officer/flagman	<input type="checkbox"/> 6 <input type="checkbox"/> Two way left turn lanes	<input type="checkbox"/> 6 <input type="checkbox"/> Other (specify)	NAME OF INVESTIGATING POLICY AGENCY	
	<input type="checkbox"/> 7 <input type="checkbox"/> Yield sign	<input type="checkbox"/> 1 <input type="checkbox"/> Separated		INVESTIGATING AGENCY REPORT NO.	
	<input type="checkbox"/> 8 <input type="checkbox"/> No traffic control	<input type="checkbox"/> 2 <input type="checkbox"/> Divided			
	<input type="checkbox"/> 9 <input type="checkbox"/> Other	<input type="checkbox"/> 3 <input type="checkbox"/> Undivided			
<b>SIGNATURE (Required)</b>				<b>DATE</b>	