



Institutional Compliance
3000 College Drive S.
Lethbridge Alberta T1K 1L6
Tel. 403.320.3361
Fax 1.888.546.4509
compliance@lethbridgecollege.ca

AUTO LOSS REPORTING FORM

FOIP Notification: The personal information requested on this form is collected under the authority of the Freedom of Information and Protection of Privacy Act (Alberta), section 33(c) and is protected by Part 2 of that Act. Your information will be used to document and/or track the incident reported on this form. Information provided may be disclosed within Lethbridge College or to external agencies as necessary to fulfill the purpose of collection, facilitate the delivery of college programs/services, to meet legislative requirements or for uses consistent with these purposes. Questions about the collection, use, disclosure or protection of the personal information being collected on this form to the college's Manager of Institutional Compliance by phoning (403) 320-3202 ext. 5703, emailing privacy@lethbridgecollege.ca, or writing to 3000 College Dr S, Lethbridge, Alberta T1K 1L6 c/o Manager of Institutional Compliance.

Instructions: Complete all sections and forward a signed copy to Institutional Compliance in person (TE 1261) or by email compliance@lethbridgecollege.ca

Retention: This form and accompanying documents are retained by the driver for 10 years, with copies retained by Institutional Compliance.

LC INSURANCE	Lethbridge College Insurer: AVIVA INSURANCE COMPANY OF CANADA		Policy Number Alcoa 107		Expiry Date: June 30, 2020	
LC VEHICLE and DRIVER	Driver's Name			Driver's License Number, Province and Class		
	Year, Make and Model and Colour of Vehicle		License Plate No. & Province		Serial No. / VIN	
DAMAGE TO OTHER VEHICLES OR TO PROPERTY OTHER THAN MOTOR VEHICLES (Attach separate page if necessary)	Vehicle 1 <input type="checkbox"/> N/A					
	Driver Name			Driver's License Number, Province and Class		
	Address			Phone		
	Year, Make and Model and Colour of Vehicle		License Plate No. & Province		Serial No. / VIN	
	Insurer Name		Policy Number		Expiry Date	
	Description of Damage					
	Vehicle 2 <input type="checkbox"/> N/A					
	Driver Name			Driver's License Number, Province and Class		
	Address			Phone		
	Year, Make and Model and Colour of Vehicle		License Plate No. & Province		Serial No. / VIN	
	Insurer Name		Policy Number		Expiry Date	
	Description of Damage					
WITNESSES	<input type="checkbox"/> Witness <input type="checkbox"/> Passenger 1		<input type="checkbox"/> Witness <input type="checkbox"/> Passenger 2		<input type="checkbox"/> Witness <input type="checkbox"/> Passenger 3	
	Name		Name		Name	
	Address		Address		Address	
	Phone		Phone		Phone	
	Injured <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Name and Address		Injured <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Name and Address	
	Nature of Injury		Nature of Injury		Nature of Injury	
	In Which Car		In Which Car		In Which Car	
	<input type="checkbox"/> Your Car	<input type="checkbox"/> Other Car #1	<input type="checkbox"/> Your Car	<input type="checkbox"/> Other Car #1	<input type="checkbox"/> Your Car	<input type="checkbox"/> Other Car #1
	<input type="checkbox"/> Other Car #2	<input type="checkbox"/> Other	<input type="checkbox"/> Other Car #2	<input type="checkbox"/> Other	<input type="checkbox"/> Other Car #2	<input type="checkbox"/> Other

COLLISION DETAIL (attach sheet if necessary)	Date	Time	Location	
	<input type="checkbox"/> AM <input type="checkbox"/> PM			
	Light Conditions			
	<input type="checkbox"/> Daylight <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark – with streetlights <input type="checkbox"/> Dark – no streetlights <input type="checkbox"/> Other:			
	Road Conditions			
	<input type="checkbox"/> Dry <input type="checkbox"/> Snow Covered <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Clear <input type="checkbox"/> Debris <input type="checkbox"/> Other:			
	Weather Conditions			
	<input type="checkbox"/> Clear <input type="checkbox"/> Fog <input type="checkbox"/> Hail <input type="checkbox"/> Cloudy <input type="checkbox"/> Snowing <input type="checkbox"/> Raining <input type="checkbox"/> Other:			
		Your Vehicle	Vehicle 1	Vehicle 2
	Direction Headed			
	Side of Street			
	Rate of Speed	<input type="checkbox"/> KPH <input type="checkbox"/> MPH	<input type="checkbox"/> KPH <input type="checkbox"/> MPH	<input type="checkbox"/> KPH <input type="checkbox"/> MPH
Blew Horn	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gave Signal	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lights	<input type="checkbox"/> Bright <input type="checkbox"/> Dim	<input type="checkbox"/> Bright <input type="checkbox"/> Dim	<input type="checkbox"/> Bright <input type="checkbox"/> Dim	
Police Report Made	Police Report Number	Officer Name and Badge Number		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
How accident occurred				

DIAGRAM OF SCENE

NOTE: Mark directions North, South, East, West, plainly

Complete sketch to show position of vehicle(s), and indicate direction of movement by an arrow thus →

Page 2 of 2