

DRIVER'S ACCIDENT REPORTING FORM

To be completed at accident scene.

Driver's Name: _____ Age _____
License#: _____
Phone#: _____
College Name: _____
Equipment#: _____ Tractor: _____ TLR: _____

DATE, TIME & PLACE

Date: _____ Time: _____ AM PM
City/Town: _____ County: _____ ST: _____
Street/HWY: _____
Address/Intersection: _____
Distance and Direction from - Nearest Community Junction: _____

Open Country Business-Shopping Residential Manufacturing/Industrial
 Other (Describe) _____

WITNESS(ES)

Persons seeing the accident will be of service to our driver by giving their names and addresses.

Name: _____
Address: _____ Phone: _____
Name: _____
Address: _____ Phone: _____
Licensing number and description of first vehicles at scene: _____

INVESTIGATING OFFICER

Name: _____
Badge#: _____ Department: _____

THOSE INVOLVED (PLEASE ATTACH ANY ADDITIONAL INFORMATION)

Company Vehicle (VEHICLE #1)

Make & Model: _____
VIN #: _____ Fleet#: _____
License Plate/Tag# & State: _____

Other Vehicle (VEHICLE #2)

Make & Model: _____
License Plate/Tag# & State: _____
Driver: _____
Address: _____
Driver's License#: _____
Name, Address & Phone of Owner (if NOT Driver): List under "Additional Information"

Other Vehicle (VEHICLE #3)

Make & Model: _____
License Plate/Tag# & State: _____
Driver: _____
Address: _____
Driver's License#: _____
Name, Address & Phone of Owner (if NOT Driver): List under "Additional Information"

INJURED PERSON

Number of persons injured _____ Killed _____
Name: _____
Address: _____
Where were they taken? _____
Name: _____
Address: _____
Where were they taken? _____
Describe Property Damage: _____

TYPE OF ACCIDENT Collision with Other Vehicle Collision with Fixed Object

	Vehicle #1	Vehicle #2	Vehicle #3	Other
<input type="checkbox"/> Ran off the Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overturned in Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mechanical Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Loading or Unloading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Boarding/Alighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant Fell Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant Injured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant Injured Inside Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____				

PEDESTRIAN ACTION

Crossing at Intersection Between Intersections With Signal Against Signal
 No Signal Diagonally Sidewalk No Sidewalk
 Walking in Roadway With Traffic Against Traffic
 Other _____

VEHICLE MOVEMENT

	Vehicle #1	Vehicle #2	Vehicle #3	Other
Straight Ahead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slowing or Stopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stopping in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting from Curb or Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U-Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skidding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overtaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrong Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowded Off Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evasive Action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____				

