PAGE _____ OF _____

MISSISSIPPI UNIFORM ACCIDENT REPORT

58 CASE NUMBER LOCAL AGENCY AND / OR OFFICER'S NAME / BADGE NUMBER

54 CASE NUMBER (DPS USE ONLY) | 55 AGENCY FILING THIS REPORT | 56 CODE | 57 STATION-PRECINCT-TROOP

59 DATE OF COLLISION: MONTH | DAY | YEAR

60 DAY OF COLLISION: S | M | T | W | TH | F | S

61 TIME (USE 2400 HRS) OF COLLISION | 62 NO. OF VEHICLES | 63 NUMBER KILLED | 64 NUMBER INJURED | 65 TIME (USE 2400 HRS) ARRIVED | 66 COUNTY | 67 CITY OR TOWN

68 HWY NO. ON | or STREET NAME, ROAD NAME, ETC. | 69 AT ☐ INTER WITH ☐ NON INTER | 70 ☐ FT ☐ N ☐ E ☐ MI ☐ S ☐ W | NEAREST INT., CO. LINE, ETC.

71 (circle) V1 V3 | PARKED VEH. | PEDESTRIAN | PEDALCYCLIST | 100 (circle) V2 V4 | PARKED VEH. | PEDESTRIAN | PEDALCYCLIST

72 DRIVER'S LAST NAME | FIRST NAME | MI | 101 DRIVER'S LAST NAME | FIRST NAME | MI

73 NUMBER AND STREET | 102 NUMBER AND STREET

74 CITY | STATE | 103 CITY | STATE

75 DRIVER'S LICENSE NUMBER | 76 STATE | 77 DOB | 78 RACE | 79 SEX | 104 DRIVER'S LICENSE NUMBER | 105 STATE | 106 DOB | 107 RACE | 108 SEX

80 SOCIAL SECURITY NO. ☐ SAME AS D.L. # | TEL. NO. | 109 SOCIAL SECURITY NO. ☐ SAME AS D.L. # | TEL. NO.

81 INSURANCE CO. OR AGENT DRIVER STATEMENT | 110 INSURANCE CO. OR AGENT DRIVER STATEMENT

82 PLACE OF EMPLOYMENT | 111 PLACE OF EMPLOYMENT

83 OWNERS LAST NAME | FIRST | MI | 112 OWNERS LAST NAME | FIRST | MI

☐ SAME AS DRIVER | ☐ SAME AS DRIVER

84 NUMBER AND STREET | 113 NUMBER AND STREET

85 CITY | STATE | 86 VEH. COLOR | 114 CITY | STATE | 115 VEH. COLOR

87 MAKE OF VEHICLE | 88 YEAR | 89 LICENSE PLATE NO. | 90 ST. | YR. | 116 MAKE OF VEHICLE | 117 YEAR | 118 LICENSE PLATE NO. | 119 ST. | YR.

91 VEHICLE REMOVED TO | 93 AUTH. 1. OWNER 2. DRIVER 3. POLICE | 120 VEHICLE REMOVED TO | 122 AUTH. 1. OWNER 2. DRIVER 3. POLICE

92 VEHICLE REMOVED BY | 121 VEHICLE REMOVED BY

94 EST. PROP. DAMAGE ☐ NONE ☐ LIGHT ☐ HEAVY | 95 SPD. ZONED | 96 V1 DR EST SPD. | 97 V2 DR EST SPD. | 123 EMS AGENCY | 124 EST. PROP. DAMAGE ☐ NONE ☐ LIGHT ☐ HEAVY

OVER

SR-1 (SHORT FORM)

You are required to complete and mail this motor vehicle accident report to the Department of Public Safety, Safet Responsibility, Post Office Box 958, Jackson, Mississippi 39205 within ten days. Failure to file this report may result i the suspension of your driving privilege and/or registration.

On the day of the accident was the vehicle involved covered by liability insurance? Yes _____ No _____

Name of insurance company: _____

Insurance policy number: _____

Name of insurance agency: _____

Was anyone seriously injured? Yes _____ No _____

Approximate cost to repair your vehicle: _____

Name of driver: _____ Dr. Lic. # _____

Name of person completing report: _____

Date of accident: _____ City or County accident happened: _____