

TOTAL NUMBER OF VEHICLES INVOLVED	DATE OF ACCIDENT	MO. DAY YR.	DAY OF ACCIDENT	Sun. M T W T F Sat.	TIME OF ACCIDENT	MILITARY TIME	FOR STATE USE ONLY	
	PLACE OF ACCIDENT	COUNTY:		CITY:		YES <input type="checkbox"/> NO <input type="checkbox"/>		
	ROAD ON WHICH ACCIDENT OCCURRED	STREET OR HIGHWAY NO.: (If No Highway Number, Identify By Name)						
	DISTANCE FROM MILEPOST	FEET:	N S E W	OF MILEPOST:	HIGHWAY NO.:	YES <input type="checkbox"/> NO <input type="checkbox"/>		Dist.
IF AT INTERSECTION				IF NOT AT INTERSECTION				
NAME OF INTERSECTING ROADWAY:				FEET:	N S E W	OF NEAREST STREET OR HIGHWAY, BRIDGE, RAILROAD CROSSING OR MILEPOST:		
IF ACCIDENT WAS OUTSIDE CITY LIMITS, INDICATE DISTANCE FROM NEAREST TOWN		MILES:	N S E W	AND MILES:	N S E W	OF NEAREST CITY OR TOWN:		

YOUR VEHICLE - 1				OTHER VEHICLE - 2			
DRIVER:		PHONE:		DRIVER:		PHONE:	
DRIVER'S ADDRESS:				DRIVER'S ADDRESS:			
CITY, STATE, ZIP:		CITY, STATE, ZIP:		CITY, STATE, ZIP:		CITY, STATE, ZIP:	
DRIVER'S LICENSE	STATE: NUMBER:	DATE OF BIRTH	SEX	DRIVER'S LICENSE	STATE: NUMBER:	DATE OF BIRTH	SEX
LICENSE PLATE	YEAR: STATE: NUMBER:	ESTIMATED DAMAGE:		LICENSE PLATE	YEAR: STATE: NUMBER:	ESTIMATED DAMAGE:	
YEAR: MAKE: MODEL: BODY STYLE: COLOR:	VEHICLE I.D. NUMBER (VIN):			YEAR: MAKE: MODEL: BODY STYLE: COLOR:	VEHICLE I.D. NUMBER (VIN):		
OWNER:		PHONE:		OWNER:		PHONE:	
OWNER'S ADDRESS:				OWNER'S ADDRESS:			
CITY, STATE, ZIP:				CITY, STATE, ZIP:			

VEHICLE MOVEMENT BEFORE COLLISION		CIRCLE THE NUMBER INDICATING POINT OF IMPACT AND SHOW ALL DAMAGED AREAS BY SHADING THE VEHICLE		Disposition of Vehicle (Check one per vehicle)	
VEH. NO. N S E W	ROAD OR HIGHWAY NAME	YOUR VEHICLE NO. 1 		VEHICLE 1 2 1 <input type="checkbox"/> Towed-due to damages 2 <input type="checkbox"/> Towed-other reasons 3 <input type="checkbox"/> Left at scene 4 <input type="checkbox"/> Driven away 5 <input type="checkbox"/> Unknown	
VEHICLE 1 2 1 <input type="checkbox"/> Going ahead 2 <input type="checkbox"/> Passing 3 <input type="checkbox"/> Turning right 4 <input type="checkbox"/> Turning left 5 <input type="checkbox"/> Making "U" turn 6 <input type="checkbox"/> Slowing down 7 <input type="checkbox"/> Starting in traffic lane 8 <input type="checkbox"/> Starting from parked position	VEHICLE 1 2 9 <input type="checkbox"/> Backing up 10 <input type="checkbox"/> Stopped in traffic lane 11 <input type="checkbox"/> Stalled in traffic lane 12 <input type="checkbox"/> Parked 13 <input type="checkbox"/> Improperly parked 14 <input type="checkbox"/> Merging 15 <input type="checkbox"/> Changing lanes	OTHER VEHICLE NO. 2 		Vehicle Condition (Check one per vehicle) VEHICLE 1 2 1 <input type="checkbox"/> No apparent defects 2 <input type="checkbox"/> Defective brakes 3 <input type="checkbox"/> Defective lights 4 <input type="checkbox"/> Defective signals 5 <input type="checkbox"/> Defective steering VEHICLE 1 2 6 <input type="checkbox"/> Defective tires 7 <input type="checkbox"/> Unknown 8 <input type="checkbox"/> Other (Specify)	

FOR EACH OCCUPANT, ENTER A RESTRAINT CODE FOR THEIR SEATING POSITION		AIR BAG	DID AIR BAG DEPLOY?	<input checked="" type="checkbox"/> IF NO AIR BAG AVAILABLE	HELMET USE	MOTOR-CYCLE	BICYCLE
YOUR VEHICLE	1 - No restraint available 2 - Restraint not used 3 - Lap belt 4 - Lap and shoulder belt 5 - Automatic belt 6 - Child restraint 7 - Unknown	SEAT POSITION	YES NO		Operator	YES NO	YES NO
		Driver Seat			Passenger		
		Front Passenger					

ENTER THE CODE WHICH BEST ANSWERS QUESTIONS 1-5 IN THE APPROPRIATE BOX TO THE RIGHT				
1 SEATING POSITION (Enter one code from 1 to 20)	2 EJECTED/TRAPPED (Enter one)	3 BODY REGION WITH MOST SEVERE INJURY (Enter one)	4 INJURY SEVERITY (Enter one)	5 TRANSPORTED TO MEDICAL FACILITY (Enter one)
10. Other enclosed passenger/cargo area 11. Other unenclosed passenger/cargo area 12. Riding on vehicle exterior 13. Sleeper section of truck cab 14. Trailing unit 15. Moped 16. Motorcycle operator 17. Motorcycle passenger 18. Pedestrian 19. Bicycle 20. Unknown	1. Not ejected or trapped 2. Partially ejected 3. Totally ejected 4. Trapped - Occupant removed without use of equipment 5. Trapped - Equipment used in extrication 6. Unknown	1. Head 2. Face 3. Neck 4. Chest 5. Back/spine 6. Shoulder/upper arm 7. Elbow/lower arm/hand 8. Abdomen/pelvis 9. Hip/upper leg 10. Knee/lower leg/foot 11. Entire body 12. Unknown	1. Killed 2. Disabling - cannot leave scene without assistance (broken bones, severe cuts, prolonged unconsciousness, etc.) 3. Visible but not disabling (minor cuts, swelling, etc.) 4. Possible but not visible (complaint of pain, etc.)	Was the individual transported from the crash site to a medical facility for treatment of injuries received in the crash? 1. Yes 2. No 3. Unknown
NAME: ADDRESS:		DATE OF BIRTH: SEX M F		1 2 3 4 5
NAME: ADDRESS:		SEAT Pos. Eject. Body Reg. Inj. Sev. Trans.		
NAME: ADDRESS:				
NAME: ADDRESS:				

DO NOT DETACH	DRIVER MUST COMPLETE IN FULL	DO NOT DETACH
You, the driver, must provide information about the liability insurance covering the motor vehicle you were driving. Please complete the following.		
Name of Insurance Company Affording Liability Coverage on Date of Accident		
Address		
Description of Car VIN No. Year Make Model		
Name of Agent Who Sold Policy Address		
Policy No. Date of Accident In or near Nebr.		
Driver Address		
Owner Address		
Name of Policyholder		