

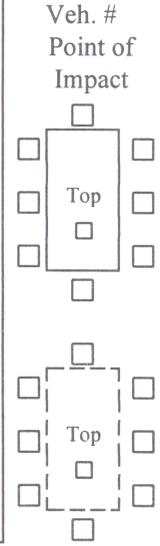
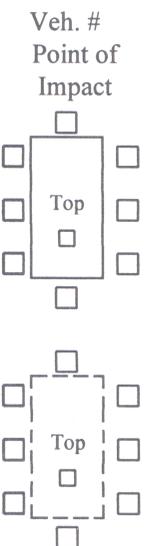




VEHICLE # OR PEDESTRIAN #

VEHICLE # OR PEDESTRIAN #

<input type="checkbox"/> Towed Away By ( Give Full Business or Person Name (First, MI, Last))		<input type="checkbox"/> Towed Away By ( Give Full Business or Person Name (First, MI, Last))	
<input type="checkbox"/> Driven Away By		<input type="checkbox"/> Driven Away By	
Address ( No. + Street / Route /P.O. Box, Etc.)		Address ( No. + Street / Route /P.O. Box, Etc.)	
City	State	Zip	City State Zip
EMS Notified <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Transported By		EMS Notified <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Transported By
EMS Arrived <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.			EMS Arrived <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Injured Transported To ( Hospital Name, City, State, Zip Code )		Injured Transported To ( Hospital Name, City, State, Zip Code )	
Name of Insurance Carrier (Not Agent) and Policy Number		Name of Insurance Carrier (Not Agent) and Policy Number	
Damage To Property Other Than Vehicles	Object Struck ( House, Fence, Tree, etc. )	Owners Name (First, MI, Last ) Address (No. + Street/Route, City, State )	
		Repair Cost	
Witnesses Names ( First, MI, Last )		Home Address ( No. + Street, Route, City, State, Zip )	Age Race Sex
1			
2			
Citations Issued To (First, MI, Last Name )		Charge and Statute Number	Summons Number
1			
2			
Time Notified of Accident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Time Arrived at Accident Scene <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Date ( Month / Day / Year )	Photos <input type="checkbox"/> Yes <input type="checkbox"/> No
Trooper/Officers Name ( Rank, First, MI, Last )	Badge No.	Department	Reviewing Off. Date Report Filed
Signature :			
Vehicle #		Vehicle #	
Vehicle Color	Point of Initial Contact	Speed Limit MPH	Speed Posted <input type="checkbox"/> Yes <input type="checkbox"/> No
			Vehicle Color Point of Initial Contact



Investigator Description ( Refer to Vehicles by Operator )

Indicate North By Arrow

Narrative: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# ARKANSAS SUPPLEMENTAL COMMERCIAL MOTOR VEHICLE ACCIDENT REPORT

<b>DRIVER AND PASSENGER INFORMATION</b>																	
RPT. #: _____						Name of Driver (First, MI, Last) _____						CDL Number/ Endorsements & State _____					
Years Employed By Carrier : _____				Actual Hours Off Since Last 8 Off : _____				Est. Hours Driven Since Last 8 Off : _____									
Driver 1 <input type="checkbox"/> Normal      4 <input type="checkbox"/> Drinking      7 <input type="checkbox"/> Eyesight 2 <input type="checkbox"/> Asleep      5 <input type="checkbox"/> Drugs      8 <input type="checkbox"/> Hearing 3 <input type="checkbox"/> Sick      6 <input type="checkbox"/> Medical Waiver      9 <input type="checkbox"/> Other						Medical Examiners Certificate <input type="checkbox"/> Yes Expiration Date: _____ <input type="checkbox"/> Does Not Apply <input type="checkbox"/> No											
Driver Qualification Training ( if yes, explain ) <input type="checkbox"/> No <input type="checkbox"/> Yes : _____						Driver/Carrier at Fault in Crash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.											
Fatalities <input type="checkbox"/> Driver <input type="checkbox"/> Carrier Personnel <input type="checkbox"/> Co-Driver <input type="checkbox"/> Passengers <input type="checkbox"/> Other : _____				Injuries <input type="checkbox"/> Driver <input type="checkbox"/> Carrier Personnel <input type="checkbox"/> Co-Driver <input type="checkbox"/> Passengers <input type="checkbox"/> Other : _____				Seat Belts Installed                      In Use Driver <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Passenger <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>VEHICLE INFORMATION</b>																	
Vehicle Type	Veh. Year	No. Axles	Make	V I N	Company Number	Type of Body	Van	Flat	Tank	Car Carrier	Cement	Dump	Other				
Truck						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tractor						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Semi Trailer						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Full Trailer						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bus						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Length (Ft.) PU :	Length (Ft.) TR 1:	Length (Ft.) TR 2:	Width (In.)	Height	GVWR	Fuel Type	<input type="checkbox"/> Diesel <input type="checkbox"/> L P G										
Mechanical Defects <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other		<input type="checkbox"/> Engine <input type="checkbox"/> Transmission <input type="checkbox"/> Drive Line	<input type="checkbox"/> Coupling <input type="checkbox"/> Suspension <input type="checkbox"/> Fuel System	<input type="checkbox"/> Brakes <input type="checkbox"/> Steering	Bus Information Seating Capacity _____		Total Passengers _____										
<b>CARRIER AND TRIP INFORMATION</b>																	
Name Of Carrier ( CORPORATE BUSINESS NAME UNDER WHOSE AUTHORITY VEHICLE IS OPERATED ) _____						Source Of Carrier Name <input type="checkbox"/> Vehicle Side <input type="checkbox"/> Shipping Papers <input type="checkbox"/> Driver											
Carrier Address _____				City _____		State _____		Zip Code _____									
Type Of Operation <input type="checkbox"/> Private <input type="checkbox"/> Household Goods <input type="checkbox"/> Common Carrier <input type="checkbox"/> Passenger <input type="checkbox"/> Contract Carrier <input type="checkbox"/> Rental <input type="checkbox"/> Exempt Commodity <input type="checkbox"/> Other ( Explain Below )				Permits <input type="checkbox"/> US DOT <input type="checkbox"/> ICC/MC TRIP ORIGIN : _____ DESTINATION : _____		Permit Numbers _____											
Type Of Trip <input type="checkbox"/> Over The Road <input type="checkbox"/> Charter or Special <input type="checkbox"/> City <input type="checkbox"/> Local Pickup / Delivery <input type="checkbox"/> Regular Route <input type="checkbox"/> Other				No. of Miles From Origin To Crash Location _____													
<b>HAZARDOUS MATERIAL INVOLVEMENT</b>																	
Was This Vehicle Carrying Hazardous Materials ? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN						Did This Vehicle Have A Hazardous Material Placard ? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN											
If Yes From ↑ Indicate Name or 4 Digit Number From Diamond or Box _____						1 or 2 Digit Number From Bottom of Diamond _____											
Was Hazardous Material Released From This Vehicle's Cargo ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																	
<b>ACCIDENT INFORMATION</b>																	
Non Collision <input type="checkbox"/> Ran Off Road		<input type="checkbox"/> Jackknife <input type="checkbox"/> Overturn		<input type="checkbox"/> Units Separated <input type="checkbox"/> Loss/Spill Cargo		<input type="checkbox"/> Cargo Shift <input type="checkbox"/> Fire		<input type="checkbox"/> Other Non Collision ( Explain Below )									
Total # of Lanes : _____		Type of Highway _____		<input type="checkbox"/> Interstate <input type="checkbox"/> Non Interstate / Limited Access		<input type="checkbox"/> 4 - Lane Divided		<input type="checkbox"/> Undivided									
Accident Results <input type="checkbox"/> Explosion		<input type="checkbox"/> Fire <input type="checkbox"/> Spillage Non-Hazardous		<input type="checkbox"/> Spillage Hazardous Material <input type="checkbox"/> Property Damage		<input type="checkbox"/> Other (Explain Below) _____											
<input type="checkbox"/> Towed Away By (Give Full Business or Persons Name (First, MI, Last)) _____						Address ( No. + Street / Route / P.O. Box / etc. ) _____											
<input type="checkbox"/> Driven Away By : _____						Name of Insurance Carrier ( Not Agent ) And Policy Number _____											
Injured Transported to ( Hospital Name, City, State, Zip ) : _____																	
EMS Notified : _____				<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.   EMS Arrived : _____				<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.   Transported By : _____									
Trooper / Officers Signature : _____																	
Trooper / Officer's Name ( First, MI, Last )		Rank	Badge/Code #	Department				Reviewing Officer		Date Report Filed							

ARKANSAS SUPPLEMENTAL MOTOR VEHICLE/ANIMAL ACCIDENT REPORT

REPORT NUMBER \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  AM  PM  
Month/Day/Year

\_\_\_\_\_ HIGHWAY \_\_\_\_\_ COUNTY \_\_\_\_\_ SECTION \_\_\_\_\_ LOG MILE \_\_\_\_\_

\_\_\_\_\_ VEHICLE MAKE \_\_\_\_\_ VEHICLE MODEL \_\_\_\_\_ BODY STYLE \_\_\_\_\_ COLOR \_\_\_\_\_ YEAR \_\_\_\_\_

\_\_\_\_\_ VIN \_\_\_\_\_ VEHICLE LICENSE \_\_\_\_\_ STATE \_\_\_\_\_

\_\_\_\_\_ WHERE VEHICLE DAMAGED \_\_\_\_\_ ESTIMATE OF DAMAGE \_\_\_\_\_

\_\_\_\_\_ OWNER (First, MI, Last Name) \_\_\_\_\_ ADDRESS OF OWNER \_\_\_\_\_

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

\_\_\_\_\_ DRIVER (First, MI, Last Name) \_\_\_\_\_ ADDRESS OF DRIVER \_\_\_\_\_

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

\_\_\_\_\_ DRIVER'S LICENSE NO.  DL  CDL \_\_\_\_\_ CLASS OF LICENSE \_\_\_\_\_ STATE \_\_\_\_\_

SEAT BELT IN USE  YES  NO

DESCRIPTION OF ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF APPLICABLE  
OWNER AND/OR DISPOSITION OF ANIMAL: \_\_\_\_\_  
(First) (MI) (Last Name)

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

\_\_\_\_\_ TROOPER/OFFICERS NAME (Rank, First, MI, Last Name) \_\_\_\_\_ BADGE # \_\_\_\_\_

\_\_\_\_\_ DEPARTMENT \_\_\_\_\_ REVIEWING OFFICER \_\_\_\_\_ DATE REPORT FILED (Mo/Day/Yr) \_\_\_\_\_