

SEND ONE COPY TO:
MAIL: R.M.V.
P.O. BOX 199100
BOSTON, MA. 02119
NAME OF POLICE DEPT. SUBMITTING REPORT

NOT TO BE USED BY OPERATOR
MUST TYPE OR PRINT
COMMONWEALTH OF MASSACHUSETTS
POLICE REPORT
OF MOTOR VEHICLE ACCIDENT

REGISTRY USE ONLY

Date of Accident			Day of the Week							Hour	
Mo	Day	Yr	S	M	T	W	T	F	S	A.M.	1
			1	2	3	4	5	6	7	P.M.	2

Did you notice any indication that an operator had been taking any medication or drugs?
 1 YES 2 NO
 (explain on reverse)

To your knowledge has any operator had a history of epilepsy, heart disease, fainting spells?
 1 YES 2 NO
 (explain on reverse)

Was this Accident investigated by an Officer?
 If Yes, Check One Box Below

1 <input type="checkbox"/> Registry	4 <input type="checkbox"/> State Police
2 <input type="checkbox"/> MDC	5 <input type="checkbox"/> Local Police
3 <input type="checkbox"/> Other	

VEHICLE 1	Name of Operator	Number of Vehicles Involved	Date of Birth	1 Sex 2		
	Street Address	City/Town	State	Zip		
	Owners Name and Address (if same, write "same")			Driver's License Number and State		
	Name of Insurance Company only may be written here			Registration Number and State		
	Name of Insurance Company only may be written here	Year	Make	Type	Approximate Cost to Repair \$	
Describe Damage to Vehicle:				Fire Damage: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Parked Car: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
VEHICLE 2	Name of Operator	Phone	Zip	Date of Birth	1 Sex 2	
	Street Address	City/Town	State	Zip	Driver's License Number and State	
	Owners Name and Address (if same, write "same")			Phone	Zip	Registration Number and State
	Name of Insurance Company only may be written here			Year	Make	Type
	Name of Insurance Company only may be written here	Year	Make	Type	Approximate Cost to Repair \$	
Describe Damage to Vehicle:				Fire Damage: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Parked Car: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
OTHER	Describe Other Property Damage				Approximate Cost to Repair \$	
	Name of Property Owner				Address	
WITNESSES	Other Witnesses or Persons Present		Address		Phone	
					Bus Res.	
					Bus Res.	

Number Injured	To what hospital was injured taken?	Taken by Ambulance?	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
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INJURED 1	Name of Injured	Street	City/Town	State
	Age	Sex	INJURY SEVERITY	
	Ejected from Vehicle		RESTRAINT SYSTEMS	
	PERSON INJURED		PERSON INJURED	

INJURED 2	Name of Injured	Street	City/Town	State
	Age	Sex	INJURY SEVERITY	
	Ejected from Vehicle		RESTRAINT SYSTEMS	
	PERSON INJURED		PERSON INJURED	

INJURED 3	Name of Injured	Street	City/Town	State
	Age	Sex	INJURY SEVERITY	
	Ejected from Vehicle		RESTRAINT SYSTEMS	
	PERSON INJURED		PERSON INJURED	

NOTE: Mark all items which apply. The diagram and description of what happened (below) need not be completed if separate 8 1/2 x 11 size sheet with same detailed information is attached. Please sign report in space provided below.

LOCATION	City or Town Where Accident Occurred _____		Nearest Mile Marker _____	Number of Lanes _____	At Rotary 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	If Accident Occurred on Ramp Fill in Below: 1 <input type="checkbox"/> On ramp to route number _____ N S E W going <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/> On ramp from route number _____ N S E W going <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																						
	Street Name or Route Number _____ at intersection with _____																											
	Which direction was each vehicle traveling? Vehicle No 1 <table style="display: inline-table; border: 1px solid black;"><tr><td>N</td><td>S</td><td>E</td><td>W</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table> No 2 <table style="display: inline-table; border: 1px solid black;"><tr><td>N</td><td>S</td><td>E</td><td>W</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table>		N	S	E		W	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N	S	E	W	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Or — If not at intersection, fill in below: _____ feet <table style="display: inline-table; border: 1px solid black;"><tr><td>N</td><td>S</td><td>E</td><td>W</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table> Of nearest intersection, bridge, mile marker, railroad. Other Landmarks: _____			N	S	E	W	<input type="checkbox"/>	<input type="checkbox"/>
N	S	E	W																									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
N	S	E	W																									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
N	S	E	W																									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									

TYPE	Accident Involved Collision With:				If collision involved two or more vehicles mark one of the following:	
	1 <input type="checkbox"/> Pedestrian	4 <input type="checkbox"/> Railroad Train	7 <input type="checkbox"/> Overturned in road	8 <input type="checkbox"/> Ran off roadway — non-collision	B <input type="checkbox"/> Truck	1 <input type="checkbox"/> Rear End
2 <input type="checkbox"/> Motor Vehicle in Traffic	5 <input type="checkbox"/> Ran off roadway hit fixed object _____ feet from road	9 <input type="checkbox"/> Fixed object on shoulder sidewalk or island	A <input type="checkbox"/> School Bus	C <input type="checkbox"/> Moped	2 <input type="checkbox"/> Angle	
3 <input type="checkbox"/> Motor Vehicle Parked	6 <input type="checkbox"/> Bicycle			D <input type="checkbox"/> Other	3 <input type="checkbox"/> Head On	

COLLISION CONDITIONS	What were vehicles doing prior to accident? Mark appropriate box		Where was pedestrian located at time of accident? Mark appropriate box		ROAD SURFACE		COLLISION CONDITIONS		LIGHT CONDITIONS	
	Vehicle		X		X		X		X	
	1	2	1	2	1	2	1	2	1	2
	1	Making right turn	1	At intersection	1	Dry	1	Hit median barrier	1	Daylight
	2	Making left turn	2	Within 300 feet of intersection	2	Wet	2	Hit guard rail	2	Dawn or dusk
	3	Making U turn	3	More than 300 feet from intersection	3	Snowy	3	Hit curbing	3	Darkness — road lighted
	4	Going straight ahead	4	Walking in street with traffic	4	Icy	4	Hit abutment	4	Darkness — road unlighted
	5	Passing on right	5	Walking in street against traffic	5	Other	5	Hit signpost		
	6	Passing on left	6	Standing in street	ROAD CONDITIONS		6	Hit utility or light pole	WEATHER CONDITIONS	
	7	Stop sign	7	Getting on/off vehicle	1	No Defects	7	Hit tree	1	Clear
8	Skidding	8	Working on vehicle	2	Holes, ruts, bumps	8	Embankment	2	Foggy	
9	Slowing or stopping	9	Working in street	3	Foreign matter on surface	9	Ditch	3	Cloudy	
A	Crossing median strip	A	Playing in street	4	Defective shoulder	A	Rock ledge	4	Rain	
B	Driverless moving vehicle	B	Not in street	5	Road under construction	B	Stone wall	5	Snow	
C	Backing	C	Other	6	Other	C	Bridge rail	6	Sleet	
D	Starting in traffic	TRAFFIC CONTROLS				D	Other			
E	Starting from parked position	1	Stop sign							
F	Parked	2	Yield sign							
G	Stalled or disabled	3	Warning sign							
H	Stalled or disabled with flasher on	4	Signal light							
J	In process of parking	5	Officer or flagman							
K	Entering or exiting from alley or driveway	6	Railroad crossing gate							
L	Making right turn on red	7	Railroad automatic signal							
M	Entering median	8	Control device not working							
N	Crossed median	9	No control present							
O	Other	A	No turn on red							

INDICATE ON THIS DIAGRAM WHAT HAPPENED

Use one of these outlines to sketch the scene of your accident, writing in street or highway names or numbers.

1. Number each vehicle and show direction of travel by arrow:
2. Use solid line to show path before accident, dotted line after accident:
3. Show pedestrian by:
4. Show railroad by:
5. Show distance and direction in landmarks; identify landmarks by name or number:
6. Indicate north by arrow, as:

VIOLATIONS	Operator (mark one or more)		Operator		Operator		Operator	
	1	2	1	2	1	2	1	2
	1	Operating Under Influence of Liquor	6	Improper Passing	B	Disregarded Traffic Light	G	Leaving Scene of Accident
	2	Operating Under Influence of Drugs	7	On Wrong Side of Road Not Overlapping	C	Disregarded Warning or Stop Signs	H	Other Moving Violations (explain below)
	3	Exceeding Lawful Speed	8	Failed to Give Proper Signal	D	Disregarded Other Traffic Control	J	Operating to Endanger
	4	Failed to Grant Right of Way to Other Vehicle	9	Improper Turning Movement	E	Improper Start from Parked Position	K	Failed to Stop for a Schoolbus
	5	Failed to Grant Right of Way to Pedestrian	A	Operating Unregistered Uninsured Vehicle	F	Improper Parked Position	L	Defective Equipment
							M	No Violation
							N	Seat Belt (Operator)
							O	Seat Belt (Passenger)

Describe What Happened (Refer to Vehicles by Number) _____

Citation Number if issued _____

Signature _____ Name and Rank _____ Police Dept _____ Date _____



NOT TO BE USED BY OPERATOR

MUST TYPE OR PRINT

COMMONWEALTH OF MASSACHUSETTS TRUCK & BUS SUPPLEMENTAL ACCIDENT REPORT

SEND BOTH SUPPLEMENTAL COPIES ALONG WITH POLICE REPORT TO. REGISTRAR OF MOTOR VEHICLES 100 NASHUA STREET BOSTON, MASS. 02114 NAME OF POLICE DEPT. SUBMITTING REPORT

WHEN TO USE THIS FORM: Answers to questions below determine use.

Did this accident involve:

- 1. a truck with at least 2 axles and six tires, or haz mat placard?
2. a bus with seats for more than 15 people, including driver?

STOP. if response to both questions is "No" do not fill out this form.

If response is "Yes" to 1 or 2, proceed to question 3.

Did this accident result in:

- 3. person(s) fatally injured?
4. injured person(s) taken away for medical attention?
5. vehicle(s) towed from scene?

STOP. If response to 3, 4, and 5, is "No" do not complete this form.

If response is "Yes" to 3, 4, or 5 please complete this form.

Main form containing fields for US DOT, State Number, Issuing State, Police Dept ID, Interstate, ICC MC #, Carrier Name, Source, Street Address, City/Town, State, Zip Code, Accident Date, Accident Time, Accident Location, City/Town, County, State, Driver's Name, Date of Birth, License Number, State, Vehicle Configuration, Total Length, Cargo Body Type, Number of axles, Gross Vehicle Wt. Rating, VIN #, Vehicle Registration #, Haz Mat Placard, Haz Mat Release of Cargo, Haz Mat Name, Haz Mat 4-Digit Number, Haz Mat 1-Digit Number, Federally Reportable?, CDL Class/Endorsement, Commercial Vehicle Driving Experience, Driver Type, and Sequence of Events.

** IN ADDITION YOU MUST CONTINUE TO SUBMIT POLICE ACCIDENT REPORT FORM E-65 TO THE REGISTRY OF MOTOR VEHICLES**

GENERAL INSTRUCTION

WHAT TO FILL OUT: Complete all questions on form for any accident that qualifies as being reportable under the conditions indicated under the heading **WHEN TO USE FORM:**

- Single truck or bus accidents** - Complete all questions.
- Multiple truck or bus accidents** - This report should be filed for **each** Motor Carrier.

DATA ELEMENT INSTRUCTIONS

ACCIDENT INFORMATION

US DOT: Enter 6-digit number.

State Number: Enter DPU or State issued Carrier Identification Number.

Issuing State of State #: Enter issuing State abbreviation.

Police Dept. ID: Enter the report, accident, document, complaint or other number that identifies the regular police accident report that collects other information on this accident.

Interstate - (Y/N): Commerce, traffic or trade across a state line.

ICC MC #: Enter 5 or 6-digit number.

Carrier Name: Enter the name of the motor carrier company from the **first** available source (vehicle side, driver or shipping papers) and check the appropriate source on the form.

Carrier's Address: Enter carrier's principal place of business (Street Address, City/Town, State and Zip Code).

Accident Date: Enter month, day and year.

Accident Time: Enter hours and minutes (24 hour time)

Accident Location: Enter Number/Name of Highway/Street, City/Town, County and State where accident occurred.

Driver's Identification: Enter Truck or Bus driver's name, Date of Birth, License Number and State of issue.

Vehicle Configuration: Enter number which best describes vehicle; enter Total Length of vehicle, Trailer width and Trailer Length or Other.

Cargo Body Type: Enter number which best describes vehicle.

Number of Axles: Enter the total number of axles on the truck or bus. Include the axles on truck semi-trailers, trailers and converter dollies.

Gross Vehicle Weight Rating: Enter rating in lbs. as listed on manufacturer's ID plate.

Vin #: Enter Vehicle Identification Number assigned by manufacturer.

Vehicle Registration #: Enter registration number, plate type and State of issue.

Haz Mat Placard?: Enter Y(Yes) or N(No) see Title 49 CFR part 172.500.

Haz Mat Release of Cargo?: Enter Y(Yes) or N(No) (Don't count fuel from fuel tank).

Haz Mat Name: Enter name (if applicable) as found in center of placard.

Haz Mat 4-Digit Number: (If applicable) enter the 4-digit number or the name from either the middle of the diamond placard or the rectangular box placard.

Haz Mat 1-Digit Number: Enter number from bottom of diamond.

Federally Reportable?: Enter Y(Yes) or N(No) as defined in Title 49 CFR part 394.7.

CDL Class/Endorsement: Applicable to Commercial Driver's License.

Commercial Vehicle Driving Experience: Enter years and months.

Driver Type: Check one.

Sequence of Events: Enter 1, 2, 3 or 4 in front of items that best describe the sequence of events for this truck or bus only.

Signature: _____

Name and Rank

Badge #

Police Dept.

Date

*** Be sure to sign both copies.**