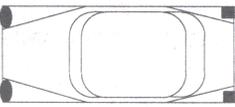
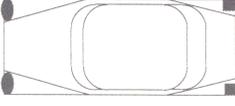


POLICE INCIDENT / CASE NUMBER	CRASH DATE	M T W T H F S S N	CRASH TIME	AM PM	POLICE NOTIFIED	AM PM	POLICE ARRIVAL	AM PM	DMV FILE NUMBER
COUNTY	ROAD ON WHICH CRASH OCCURRED						MILE POST	DMV CODE	

WITHIN \_\_\_\_\_ FEET N S OF NEAREST INTERSECTING ROAD  
 NEAR \_\_\_\_\_ MILES E W  
 WITHIN \_\_\_\_\_ FEET N S OF NEAREST CITY / TOWN  
 NEAR \_\_\_\_\_ MILES E W  
 PROPERTY DAMAGE     PUBLIC PROPERTY DAMAGE     INJURY     FATAL     HAZARDOUS MATERIALS     HIT AND RUN     PHOTOS TAKEN     TRAIN R/R     TRUCK / BUS

UNIT #	NAME (LAST, FIRST, MIDDLE)				DRIVER LICENSE NUMBER		STATE	SEX	RACE	DOB	
PED BIC PRK PRP	ADDRESS						HOME PHONE ( )				
VEHICLE OWNER						WORK PHONE ( )					
INSURANCE COMPANY						INSURANCE POLICY NUMBER					
FIRE Y N	STD SPD	PST SPD	EJECTED Y P N	EXTRCTD Y N	VEHICLE IDENTIFICATION NUMBER (VIN)	LICENSE PLATE NUMBER	STATE	YEAR	MAKE	MODEL / STYLE	COLOR
VEHICLE TOWED: Y N					DRIVER TAKEN: Y N		UNKNOWN				
VEHICLE DAMAGE					DAMAGE ESTIMATE		INJURY:				
FRONT 					<input type="checkbox"/> NONE <input type="checkbox"/> ROLLOVER <input type="checkbox"/> UNDER \$1000 <input type="checkbox"/> UNDERCAR <input type="checkbox"/> OVER \$1000 <input type="checkbox"/> TOTALED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> UNKNOWN		<input type="checkbox"/> NONE <input type="checkbox"/> POSSIBLE <input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS <input type="checkbox"/> FATAL				
					USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)		EQUIPMENT: <input type="checkbox"/> NO EQP USED <input type="checkbox"/> LAP ONLY <input type="checkbox"/> LAP / SHLDR <input type="checkbox"/> CHLD RST-PRP <input type="checkbox"/> A/BAG-DEPLYD <input type="checkbox"/> NONE INSTLD <input type="checkbox"/> UNKNOWN <input type="checkbox"/> SHLDR ONLY <input type="checkbox"/> HELMET <input type="checkbox"/> CHLD RST-IMPR <input type="checkbox"/> A/BAG-NOT DP				
ACTION / ARREST / CITES											

HIT AND RUN	SUSPECT NAME							AKA	IN CUSTODY Y N
	ADDRESS							OTHER INFORMATION:	
	SEX	RACE	DOB	HT	WT	HAIR	EYES	LOCAL ID	

UNIT #	NAME (LAST, FIRST, MIDDLE)				DRIVER LICENSE NUMBER		STATE	SEX	RACE	DOB	
PED BIC PRK PRP	ADDRESS						HOME PHONE ( )				
VEHICLE OWNER						WORK PHONE ( )					
INSURANCE COMPANY						INSURANCE POLICY NUMBER					
FIRE Y N	STD SPD	PST SPD	EJECTED Y P N	EXTRCTD Y N	VEHICLE IDENTIFICATION NUMBER (VIN)	LICENSE PLATE NUMBER	STATE	YEAR	MAKE	MODEL / STYLE	COLOR
VEHICLE TOWED: Y N					DRIVER TAKEN: Y N		UNKNOWN				
VEHICLE DAMAGE					DAMAGE ESTIMATE		INJURY:				
FRONT 					<input type="checkbox"/> NONE <input type="checkbox"/> ROLLOVER <input type="checkbox"/> UNDER \$1000 <input type="checkbox"/> UNDERCAR <input type="checkbox"/> OVER \$1000 <input type="checkbox"/> TOTALED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> UNKNOWN		<input type="checkbox"/> NONE <input type="checkbox"/> POSSIBLE <input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS <input type="checkbox"/> FATAL				
					USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)		EQUIPMENT: <input type="checkbox"/> NO EQP USED <input type="checkbox"/> LAP ONLY <input type="checkbox"/> LAP / SHLDR <input type="checkbox"/> CHLD RST-PRP <input type="checkbox"/> A/BAG-DEPLYD <input type="checkbox"/> NONE INSTLD <input type="checkbox"/> UNKNOWN <input type="checkbox"/> SHLDR ONLY <input type="checkbox"/> HELMET <input type="checkbox"/> CHLD RST-IMPR <input type="checkbox"/> A/BAG-NOT DP				
ACTION / ARREST / CITES											

UNIT #	PASSENGER NAME				ADDRESS								
<input type="checkbox"/> WITNESS													
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	INJURY		LOCATION		OTHER:	EJECTED Y P N	EXTRCTD Y N		
PASSENGER TAKEN: Y N					EQUIPMENT		NO EQP USED		LAP ONLY		LAP / SHLDR	CHLD RST-PRP	A/BAG-DEPLYD
BY:					NONE INSTLD		UNKNOWN		SHLDR ONLY		HELMET	CHLD RST-IMPR	A/BAG-NOT DP
UNIT #	PASSENGER NAME				ADDRESS								
<input type="checkbox"/> WITNESS													
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	INJURY		LOCATION		OTHER:	EJECTED Y P N	EXTRCTD Y N		
PASSENGER TAKEN: Y N					EQUIPMENT		NO EQP USED		LAP ONLY		LAP / SHLDR	CHLD RST-PRP	A/BAG-DEPLYD
BY:					NONE INSTLD		UNKNOWN		SHLDR ONLY		HELMET	CHLD RST-IMPR	A/BAG-NOT DP
UNIT #	PASSENGER NAME				ADDRESS								
<input type="checkbox"/> WITNESS													
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	INJURY		LOCATION		OTHER:	EJECTED Y P N	EXTRCTD Y N		
PASSENGER TAKEN: Y N					EQUIPMENT		NO EQP USED		LAP ONLY		LAP / SHLDR	CHLD RST-PRP	A/BAG-DEPLYD
BY:					NONE INSTLD		UNKNOWN		SHLDR ONLY		HELMET	CHLD RST-IMPR	A/BAG-NOT DP

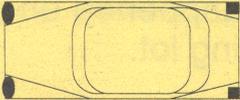
DISTRIBUTION			
OFFICER NAME / NUMBER	DATE	AGENCY	APPROVED BY

Check ONE box in all categories. Check ALL boxes that apply in categories with (★).

FIRST HARMFUL EVENT	WEATHER	ROAD CHARACTER	★ VEH RELATED FACTORS	TRUCK CONFIGURATION	PEDESTRIAN TYPE
<b>NON COLLISION</b> <input type="checkbox"/> OVERTURN <input type="checkbox"/> FIRE / EXPLOSION <input type="checkbox"/> IMMERSION <input type="checkbox"/> GAS INHALATION <input type="checkbox"/> OTHER NON COLLISION <input type="checkbox"/> MEDICAL (Explain)	<input type="checkbox"/> CLEAR <input type="checkbox"/> CLOUDY (OVERCAST) <input type="checkbox"/> RAIN <input type="checkbox"/> SNOW <input type="checkbox"/> SLEET / HAIL / ETC <input type="checkbox"/> FOG / SMOG <input type="checkbox"/> SMOKE <input type="checkbox"/> BLOWING SAND / DIRT <input type="checkbox"/> SEVERE CROSSWIND <input type="checkbox"/> OTHER / UNKNOWN	<b>#1 #2</b> <input type="checkbox"/> STRAIGHT and LEVEL <input type="checkbox"/> STRAIGHT w/ GRADE <input type="checkbox"/> CURVED and LEVEL <input type="checkbox"/> CURVED w/ GRADE  <b>VEH #1</b> — NUMBER OF LANES  <b>VEH #2</b> — NUMBER OF LANES  <b>— TOTAL NUMBER OF LANES</b> <b>ROAD FLOW</b> <b>DIVIDED MEDIAN</b> <b>#1 #2</b> <input type="checkbox"/> UNPAVED <input type="checkbox"/> BARRIER <input type="checkbox"/> PAVED <input type="checkbox"/> CONT LEFT TURN <b>OTHER</b> <input type="checkbox"/> ONE WAY TRAFFIC <input type="checkbox"/> NOT PHYSLY DIVIDED	<b>#1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> BRAKES <input type="checkbox"/> STEERING <input type="checkbox"/> POWER PLANT <input type="checkbox"/> SUSPENSION <input type="checkbox"/> TIRES <input type="checkbox"/> EXHAUST <input type="checkbox"/> LIGHTS <input type="checkbox"/> SIGNALS <input type="checkbox"/> WINDOWS / WINDSHLD <input type="checkbox"/> RESTRAINT SYSTEM <input type="checkbox"/> WHEELS <input type="checkbox"/> COUPLING <input type="checkbox"/> CARGO <input type="checkbox"/> OTHER  <b>VEHICLE MOVEMENT</b> <b>#1 #2</b> <input type="checkbox"/> BACKING <input type="checkbox"/> STOPPED <input type="checkbox"/> STRAIGHT AHEAD <input type="checkbox"/> TURNING RIGHT <input type="checkbox"/> TURNING LEFT <input type="checkbox"/> MAKING U-TURN <input type="checkbox"/> ENTER TRAFFIC LANE <input type="checkbox"/> LEAVE TRAFFIC LANE <input type="checkbox"/> OVERTAKING <input type="checkbox"/> CHANGING LANES <input type="checkbox"/> AVOIDING MANEUVER <input type="checkbox"/> MERGING <input type="checkbox"/> PARKING <input type="checkbox"/> NEGOTIATING A CURVE <input type="checkbox"/> OTHER  <b>TRAILER TYPE</b> <b>#1 #2</b> <input type="checkbox"/> LOG BUNK <input type="checkbox"/> SEMITRAILER <input type="checkbox"/> POLE TRAILER <input type="checkbox"/> FULL TRAILER <input type="checkbox"/> MOBILE HOME <input type="checkbox"/> UTILITY TRAILER <input type="checkbox"/> TRAVEL TRAILER <input type="checkbox"/> BOAT TRAILER <input type="checkbox"/> FARM EQUIPMENT <input type="checkbox"/> HORSE TRAILER <input type="checkbox"/> VEHICLE IN TOW <input type="checkbox"/> OTHER / UNKNOWN	<b>#1 #2</b> <input type="checkbox"/> TRUCK (2 or 3 AXLE) <input type="checkbox"/> TRUCK / TRACTOR-SEMI <input type="checkbox"/> TRUCK and TRAILER <input type="checkbox"/> DOUBLE TRAILERS <input type="checkbox"/> TRIPLE TRAILERS <input type="checkbox"/> DROMEDARY and SEMI <input type="checkbox"/> HEAVY HAUL CONFIG <input type="checkbox"/> BUS <input type="checkbox"/> OTHER  <b>★ PASSENGER FACTORS</b> <b>PASS UNIT #1</b> <b>#1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> INTERFERED w/DRIVER <input type="checkbox"/> UNDER INFL - DRUGS <input type="checkbox"/> UNDER INFL - ALCOHOL <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (Explain)	<input type="checkbox"/> NONE <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> BICYCLIST <input type="checkbox"/> CONVEYANCE <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> ANIMAL RIDER <input type="checkbox"/> RIDER of ANIM DRAWN VEH <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (Explain)
<b>COLLISION WITH</b> <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PARKED MOTOR VEHICLE <input type="checkbox"/> RAILWAY TRAIN <input type="checkbox"/> BICYCLIST <b>CRASH TYPE</b> <input type="checkbox"/> HEAD ON <input type="checkbox"/> REAR END <input type="checkbox"/> ANGLE <input type="checkbox"/> SIDESWIPE <input type="checkbox"/> MANNER UNKNOWN <b>FIXED OBJECT</b> <input type="checkbox"/> BARRICADE <input type="checkbox"/> BOULDER / ROCK <input type="checkbox"/> BRIDGE O/PASS or RAILING <input type="checkbox"/> BUILDING <input type="checkbox"/> CULVERT HEADWALL <input type="checkbox"/> CURBING <input type="checkbox"/> DITCH <input type="checkbox"/> DIVIDER - CNCRT or STEEL <input type="checkbox"/> FENCE - NOT MEDIAN <input type="checkbox"/> FIRE HYDRANT <input type="checkbox"/> HIGHWAY GUARDRAIL <input type="checkbox"/> HIGHWAY SIGN <input type="checkbox"/> IMPACT ABSORBER <input type="checkbox"/> LIGHT STANDARD <input type="checkbox"/> MAILBOX <input type="checkbox"/> OVERHEAD SIGN POST <input type="checkbox"/> OVERHEAD STRUCTURE <input type="checkbox"/> PIER or COLUMN <input type="checkbox"/> RETAINING WALL <input type="checkbox"/> SIDESLOPE EARTH <input type="checkbox"/> SIDESLOPE ROCK or STONE <input type="checkbox"/> TRAFFIC SIGNAL POST <input type="checkbox"/> TREE <input type="checkbox"/> UNDERPASS TUNNEL <input type="checkbox"/> UTILITY POLE <input type="checkbox"/> OTHER FIXED (Explain)	<b>SURFACE CONDITION</b> <b>#1 #2</b> <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> SNOW / SLUSH <input type="checkbox"/> ICY <input type="checkbox"/> MUDDY <input type="checkbox"/> DEBRIS <input type="checkbox"/> RUTS / HOLES / BUMPS <input type="checkbox"/> WORN / POLISHED <input type="checkbox"/> LOW / SOFT SHOULDER <input type="checkbox"/> OTHER / UNKNOWN  <b>SURFACE TYPE</b> <b>#1 #2</b> <input type="checkbox"/> CONCRETE <input type="checkbox"/> BLACKTOP / ASPHALT <input type="checkbox"/> GRAVEL <input type="checkbox"/> DIRT <input type="checkbox"/> OTHER	<b>DRIVER LICENSE VIOLATION</b> <b>DRIVER #1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> INSTRUCTION PERMIT <input type="checkbox"/> LICENSE RESTRICTION <input type="checkbox"/> EXPIRED LICENSE <input type="checkbox"/> OUT OF CLASS <input type="checkbox"/> SUSPND / REVOKED <input type="checkbox"/> UNLICENSED	<b>★ DRIVER FACTORS</b> <b>DRIVER #1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> CELL PHONE USE <input type="checkbox"/> OBSTRUCTED VIEW <input type="checkbox"/> FAILED TO YIELD ROW <input type="checkbox"/> DISRGRD TRAF SIGN <input type="checkbox"/> TOO FAST FOR COND <input type="checkbox"/> MADE IMPROPER TURN <input type="checkbox"/> WRONG SIDE/WAY <input type="checkbox"/> FOLLOW TOO CLOSELY <input type="checkbox"/> IMPROPER LANE CHNG <input type="checkbox"/> IMPROPER BACKING <input type="checkbox"/> IMPROPER PASSING <input type="checkbox"/> IMPROPER SIGNAL <input type="checkbox"/> IMPROPER PARKING <input type="checkbox"/> FATIGUE / DROWSY <input type="checkbox"/> ILL / BLACKOUT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER	<b>PASS UNIT #2</b> <b>#1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> INTERFERED w/DRIVER <input type="checkbox"/> UNDER INFL - DRUGS <input type="checkbox"/> UNDER INFL - ALCOHOL <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (Explain)	<b>★ PEDESTRIAN ACTION</b> <input type="checkbox"/> ENTER / CROSS ROAD <input type="checkbox"/> WALK / RIDE w/TRAFF <input type="checkbox"/> WALK / RIDE AGAINST <input type="checkbox"/> STEP ON / OFF VEHICLE <input type="checkbox"/> STEP ON / OFF SCH BUS <input type="checkbox"/> APPRCH / LEAVE SC BUS <input type="checkbox"/> APPROACH / LEAVE VEH <input type="checkbox"/> WORK / PUSHING VEHICLE <input type="checkbox"/> OTHER WORKING <input type="checkbox"/> PLAYING <input type="checkbox"/> STANDING <input type="checkbox"/> LYING DOWN <input type="checkbox"/> UNKNOWN
<b>OTHER OBJECT (NOT FIXED)</b> <input type="checkbox"/> ANIMAL <input type="checkbox"/> THROWN / FALLING OBJECT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER OBJECT (Explain)	<b>LIGHT</b> <input type="checkbox"/> FULL DAYLIGHT <input type="checkbox"/> DAWN <input type="checkbox"/> DUSK <input type="checkbox"/> DARK - LIGHTED WAY <input type="checkbox"/> DARK - NOT LIGHTED <input type="checkbox"/> UNKNOWN	<b>★ IMPAIRMENT</b> <b>DRIVER #1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> UNDER INFL - DRUGS <input type="checkbox"/> UNDER INFL - ALCOHOL <input type="checkbox"/> UNDER INFL - MEDS <input type="checkbox"/> UNKNOWN	<b>PEDESTRIAN LOCATION</b> <b>IN ROAD</b> <input type="checkbox"/> IN X-WALK <input type="checkbox"/> NOT IN X-WALK <input type="checkbox"/> NO X-WALK AVAILABLE <b>INTERSECTION</b> <input type="checkbox"/> IN X-WALK <input type="checkbox"/> NOT IN X-WALK <input type="checkbox"/> NO X-WALK AVAILABLE <b>OTHER</b> <input type="checkbox"/> NOT IN ROADWAY <input type="checkbox"/> SHOULDER <input type="checkbox"/> MEDIAN <input type="checkbox"/> BIKE LANE <input type="checkbox"/> UNKNOWN	<b>PED / BIKE VISIBILITY</b> <b>CLOTHING</b> <input type="checkbox"/> NO CONTRAST w/BKGRND <input type="checkbox"/> CONTRASTED w/BKGRND <input type="checkbox"/> REFLECTIVE <b>OTHER</b> <input type="checkbox"/> OTHER LIGHT SOURCE <input type="checkbox"/> UNKNOWN <b>★ PED / BIKE FACTORS</b> <input type="checkbox"/> NONE <input type="checkbox"/> FAILED TO YIELD ROW <input type="checkbox"/> DISREGARD TRAFFIC SIGN <input type="checkbox"/> ILLEGALLY IN ROAD <input type="checkbox"/> EQUIPMENT VIOLATION <input type="checkbox"/> CLOTHING NOT VISIBLE <input type="checkbox"/> UNDER INFL - DRUGS <input type="checkbox"/> UNDER INFL - ALCOHOL <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (Explain)	
<b>EVENT LOCATION</b> <b>ON ROADWAY</b> <input type="checkbox"/> NON-INTERSECTION <input type="checkbox"/> INTERSECTION <input type="checkbox"/> INTERSECTION RELATED <input type="checkbox"/> DRIVEWAY ACCESS <input type="checkbox"/> INTERCHANGE AREA <input type="checkbox"/> RAILROAD CROSSING <input type="checkbox"/> BRIDGE <input type="checkbox"/> TUNNEL <input type="checkbox"/> OTHER ON-ROAD AREA <b>OFF ROADWAY</b> <input type="checkbox"/> SHOULDER <input type="checkbox"/> TURNOUT <input type="checkbox"/> ROADSIDE <input type="checkbox"/> BEYOND RIGHT OF WAY <input type="checkbox"/> MEDIAN <input type="checkbox"/> DRIVEWAY <input type="checkbox"/> PRIVATE DRIVE <input type="checkbox"/> RAILROAD CROSSING <input type="checkbox"/> OTHER OFF ROAD <input type="checkbox"/> PARKING LOT <input type="checkbox"/> UNKNOWN <b>SPECIAL ZONE</b> <input type="checkbox"/> NONE <input type="checkbox"/> CONSTRUCTION <input type="checkbox"/> MAINTENANCE <input type="checkbox"/> UTILITY <input type="checkbox"/> SNOW <input type="checkbox"/> SCHOOL <input type="checkbox"/> UNKNOWN WORK <input type="checkbox"/> OTHER	<b>TRAFFIC CONTROL TYPE</b> <b>#1 #2</b> <input type="checkbox"/> NONE <input type="checkbox"/> SCHOOL BUS LIGHTS <input type="checkbox"/> OFFICER / CROSSING GUARD or FLAGGER <input type="checkbox"/> TRAFFIC SIGNAL w/ PEDESTRIAN CONTROL <input type="checkbox"/> TRAFFIC SIGNAL <input type="checkbox"/> FLASHING BEACON <input type="checkbox"/> STOP SIGN <input type="checkbox"/> YIELD SIGN <input type="checkbox"/> RR CROSSING GATES <input type="checkbox"/> RR CROSSING BUCKS <input type="checkbox"/> RR FLASHING SIGNAL <input type="checkbox"/> RR CROSSING w/ PAVEMENT MARKINGS <input type="checkbox"/> LANE CONTRLS / LINES / STRIPES / DEVICES <input type="checkbox"/> SCHOOL SIGNAL <input type="checkbox"/> OTHER REG SIGN <input type="checkbox"/> UNKNOWN	<b>DETERMINED BY:</b> <input type="checkbox"/> INTOXILYZER TEST <input type="checkbox"/> BLOOD OR URINE TEST <input type="checkbox"/> FIELD SOB. TEST <input type="checkbox"/> OBSERVED (SPEECH, ODOR, ETC.) <input type="checkbox"/> DRE EVALUATION <input type="checkbox"/> STATEMENTS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER	<b>SKETCH &amp; NARRATIVE</b> UNIT 1 2 SKID MARKS TO (FEET) _____ DISTANCE AFTER (FEET) _____  <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	<b>RESULTS OF TEST:</b> <b>D1 _____% D2 _____%</b> <input type="checkbox"/> NO TEST GIVEN <input type="checkbox"/> TEST REFUSED <input type="checkbox"/> TESTED FOR DRUGS <input type="checkbox"/> RESLTS NOT AVAILABLE	

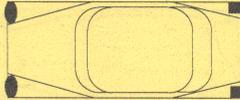
POLICE INCIDENT / CASE NUMBER	CRASH DATE	M T W T H F S S N	CRASH TIME	POLICE NOTIFIED	POLICE ARRIVAL	DMV FILE NUMBER
			AM PM	AM PM	AM PM	
COUNTY	ROAD ON WHICH CRASH OCCURRED				MILE POST	DMV CODE
<input type="checkbox"/> WITHIN _____ FEET N S OF NEAREST INTERSECTING ROAD			<input type="checkbox"/> WITHIN _____ FEET N S OF NEAREST CITY / TOWN			
<input type="checkbox"/> NEAR _____ MILES E W			<input type="checkbox"/> NEAR _____ MILES E W			
<input type="checkbox"/> PROPERTY DAMAGE		<input type="checkbox"/> PUBLIC PROPERTY DAMAGE	<input type="checkbox"/> INJURY	<input type="checkbox"/> FATAL	<input type="checkbox"/> HAZARDOUS MATERIALS	<input type="checkbox"/> HIT AND RUN
		<input type="checkbox"/> PHOTOS TAKEN	<input type="checkbox"/> TRAIN R/R	<input type="checkbox"/> TRUCK / BUS		

UNIT #	NAME (LAST, FIRST, MIDDLE)	DRIVER LICENSE NUMBER	STATE	SEX	RACE	DOB
PED	ADDRESS				HOME PHONE ( )	
BIC						
PRK	VEHICLE OWNER				WORK PHONE ( )	
PRP	<input type="checkbox"/> SAME					
INSURANCE COMPANY			INSURANCE POLICY NUMBER			
<input type="checkbox"/> NONE						

VEHICLE IDENTIFICATION NUMBER (VIN)		LICENSE PLATE NUMBER	STATE	YEAR	MAKE	MODEL / STYLE	COLOR
VEHICLE TOWED: Y N	<input type="checkbox"/> UNKNOWN	DRIVER TAKEN: Y N	<input type="checkbox"/> UNKNOWN				
BY:	TO:	BY:	TO:				
VEHICLE DAMAGE	DAMAGE ESTIMATE <input type="checkbox"/> ROLLOVER		ACTION / ARREST / CITES				
FRONT 	<input type="checkbox"/> NONE <input type="checkbox"/> UNDERCARR						
	<input type="checkbox"/> UNDER \$1000 <input type="checkbox"/> TOTALED						
	<input type="checkbox"/> OVER \$1000 <input type="checkbox"/> UNKNOWN						
USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)							



UNIT #	NAME (LAST, FIRST, MIDDLE)	DRIVER LICENSE NUMBER	STATE	SEX	RACE	DOB
PED	ADDRESS				HOME PHONE ( )	
BIC						
PRK	VEHICLE OWNER				WORK PHONE ( )	
PRP	<input type="checkbox"/> SAME					
INSURANCE COMPANY			INSURANCE POLICY NUMBER			
<input type="checkbox"/> NONE						

VEHICLE IDENTIFICATION NUMBER (VIN)		LICENSE PLATE NUMBER	STATE	YEAR	MAKE	MODEL / STYLE	COLOR
VEHICLE TOWED: Y N	<input type="checkbox"/> UNKNOWN	DRIVER TAKEN: Y N	<input type="checkbox"/> UNKNOWN				
BY:	TO:	BY:	TO:				
VEHICLE DAMAGE	DAMAGE ESTIMATE <input type="checkbox"/> ROLLOVER		ACTION / ARREST / CITES				
FRONT 	<input type="checkbox"/> NONE <input type="checkbox"/> UNDERCARR						
	<input type="checkbox"/> UNDER \$1000 <input type="checkbox"/> TOTALED						
	<input type="checkbox"/> OVER \$1000 <input type="checkbox"/> UNKNOWN						
USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)							

UNIT #	<input type="checkbox"/> PASSENGER NAME	ADDRESS			
	<input type="checkbox"/> WITNESS				
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	
PASSENGER TAKEN: Y N		<input type="checkbox"/> UNKNOWN			
BY:	TO:				

UNIT #	<input type="checkbox"/> PASSENGER NAME	ADDRESS			
	<input type="checkbox"/> WITNESS				
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	
PASSENGER TAKEN: Y N		<input type="checkbox"/> UNKNOWN			
BY:	TO:				

UNIT #	<input type="checkbox"/> PASSENGER NAME	ADDRESS			
	<input type="checkbox"/> WITNESS				
SEX	RACE	DOB	HOME PHONE ( )	WORK PHONE ( )	
PASSENGER TAKEN: Y N		<input type="checkbox"/> UNKNOWN			
BY:	TO:				

DISTRIBUTION		
OFFICER NAME / NUMBER	DATE	AGENCY

# Accident Responsibilities & Information

This Form is for Informational Purposes Only

This form has been provided to you as a courtesy. Information on this form will help you complete your personal Accident Report Form for DMV.

Oregon law requires all drivers to file an Accident Report Form with DMV within 72 hours of the accident, if the damage to any one person's property is more than \$1,000, or if any person is injured (no matter how minor the injury is), or if any person is killed. You must report an accident even if it happened on private property that is premises open to the public, like a store parking lot.

You can get an Accident Report Form from your local law enforcement agency, or your local DMV.

Failure to report an accident will result in the suspension of your driving privilege. This suspension will be effective for a period of 5 years, or until DMV receives a report, whichever is less. You may also be required to file proof of insurance for 3 years.

Oregon law requires all motor vehicle owners to maintain liability insurance coverage. DMV checks the insurance information on all accident reports. If DMV finds you were uninsured at the time of the accident, or you fail to show proof of insurance on the Accident Report Form, DMV will suspend your driving privilege for 1 year, and then you must file proof of insurance for 3 years after the suspension.

- DAMAGE ESTIMATE
- ROLLOVER
- NONE
- UNDER \$1000
- TOTALED
- OVER \$1000
- UNKNOWN





# OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

## Instructions

*Tear this sheet off your report, read and carefully follow the directions.*

**EVERY driver involved in an accident resulting in any of the following MUST file an *Accident Report*:**

- **Damage to any one person's property over \$1000;**
- **Injury (No matter how minor); or**
- **Death.**

Oregon law requires these reports be filed within 72 hours of the accident. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the accident to DMV, it may result in suspension of your driving privileges. If the police department files a police report, you are **still** required to file your own Accident Report with DMV. If you are an out-of-state resident, you are **still** required to file your own Accident Report with DMV. DMV does not determine fault in an accident, but does post the accident to the driving record of each driver involved, unless the vehicle is parked.

**PRINT OR TYPE ALL INFORMATION.** (Use black or dark blue ink and press firmly.)

- Complete both sides of the form.
- If additional vehicles were involved in the accident, complete the *Supplemental Report* (Form 735-32B), or on a blank piece of paper, write all the information as requested in the "Other Driver" section.
- Mail the form to Accident Reporting Unit, DMV, 1905 Lana Ave NE, Salem OR 97314, or deliver it to any DMV office.
- DMV headquarters will verify the insurance information submitted. Complete the insurance section or a suspension of your driving privileges may occur.

**DATE, LOCATION AND TIME** — Clearly identify the date, location and time of the accident. The correct date, location and time is critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

**YOUR INFORMATION** — DMV will consider your accident uninsured if you do not complete **ALL** of this section. You must list the insurance company name that provided liability coverage for your operation of the vehicle you were driving at the time of the accident. Note the coverage is for liability insurance, not collision or comprehensive coverage. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

Answer all of the employment questions. DMV will use the information provided in these questions to code the accident. It is important for you to understand "principal purpose of driving" and "paid to drive." These include **ONLY** persons employed or being paid for the purpose of driving, **NOT** driving to reach a destination to perform a service.

**OTHER DRIVER** — Completion of this information will help DMV match all driver's accident reports more efficiently.

**SIGNATURE** — It is important for you to sign and date the form.

**OTHER SIDE OF FORM** — Complete the other side of the form, including an explanation of what happened at the time of the accident. Information collected from both sides of this form helps officials make valuable transportation decisions about the roadway systems and driver safety.

**YOUR COPY** — Under Oregon law 802.220 (5), DMV can not provide you a copy of your *Oregon Traffic Accident and Insurance Report*. If you wish to have a complete copy of your report (front and back), **you** will need to make a copy for your records.

**RECEIPT** — Attached is a PINK courtesy copy of your report. After you have completed both sides of the form, tear the PINK copy off for your records. If you want a receipt, you must bring the form, with the PINK copy, to a DMV office. Have your copy validated. Without a receipt, you will have no proof of submitting a report.

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY CAN NOT REQUIRE REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

**NOTE TO COMMERCIAL MOTOR VEHICLE OPERATORS:** In addition to this report, Oregon Law requires Form 735-9229, Motor Carrier Accident Report, **MUST** be filed within 30 days of a commercial motor vehicle accident when there is a **FATALITY, INJURY** (requiring treatment away from the scene), or when a vehicle is **TOWED** from the scene because of damage. If you have questions regarding the *Motor Carrier Accident Report*, you can call (503) 986-3507.

# TOTALED VEHICLE NOTICE

## DEFINITIONS AND INSTRUCTIONS FOR TOTALED VEHICLES

IF YOUR ACCIDENT HAS RESULTED IN A "TOTALED" VEHICLE, YOU ARE REQUIRED BY LAW TO FOLLOW APPROPRIATE INSTRUCTIONS IN THIS NOTICE.

### DEFINITION OF "TOTALED" VEHICLE

"Totaled Vehicle" or "Totaled" as defined in Oregon law (ORS 801.527) means:

- A vehicle that is declared a total loss by an insurer who is obligated to cover the loss. Also, a vehicle that the insurer takes possession of or title to.
- A vehicle that has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80% of the retail market value prior to the damage. "Retail market value" is defined as the amount shown in publications used by financial institutions (e.g. banks, lenders) in this state.
- A vehicle that is stolen, if it is not recovered within 30 days of theft and the loss is not covered by an insurer. In this situation, you must notify DMV within 60 days of the theft.

### ▼ FOLLOW THESE INSTRUCTIONS IF YOUR VEHICLE IS TOTALED ▼

If your vehicle is totaled, in addition to completing the accident report, follow the instruction that is applicable to your case. **Either:**

1. SURRENDER the title to the insurer if the damage is covered by an insurer who declares the vehicle to be a "total loss," and the insurer takes possession of the vehicle; **or**
2. SURRENDER the title to DMV and apply for salvage title if the damage is covered by an insurer who declares the vehicle to be a "total loss," but you keep possession of the vehicle; **or**
3. SURRENDER the title to DMV and apply for salvage title if the damage was not covered by an insurer and the estimated cost of repair is at least 80% of the retail market value of the vehicle before the damage; **or**
4. NOTIFY DMV that your vehicle has been totaled if, for some reason, you are unable to obtain the title for surrender. You must provide DMV with a signed statement which includes:
  - A description of the vehicle which includes the year model, make, plate number and vehicle identification number.
  - A statement indicating the vehicle has been totaled.
  - A statement that you are unable to obtain the title and why.

**DO NOT SUBMIT THE TITLE WITH THE ACCIDENT REPORT.** You can obtain the salvage title application from any DMV office or by calling (503) 945-5000. If you have questions about salvage titles, call (503) 945-5122.

**NOTE:** It is a Class A misdemeanor with a penalty of imprisonment and/or fine if you fail to comply with the above requirements. (ORS 819.012)



# OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Complete this form ONLY if your accident is reportable under Oregon Law. The accident is reportable if it happened on a highway or premises open to the public, and resulted in any of the following: 1) More than \$1000 in damage to any one person's property; 2) Injury to any person (no matter how minor the injury); or, 3) the death of any person. (PLEASE PRINT)

LOCATION & TIME

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY	AM PM	COUNTY	<b>DO NOT WRITE IN THIS SPACE</b>	Accident Number _____	
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)						MILE POST	Accident Type Code (Circle One) <b>1 2 3 4 6 8 9 X R P</b>
<input type="checkbox"/> WITHIN _____ FEET N S E W			NAME OF NEAREST INTERSECTING ROAD			<input type="checkbox"/> WITHIN _____ FEET N S E W	NAME OF NEAREST CITY / TOWN
<input type="checkbox"/> NEAR _____ MILES N S E W						<input type="checkbox"/> NEAR _____ MILES N S E W	

YOUR INFORMATION

**TYPE OF ACCIDENT** - The accident involved one or more of the following: (Mark all that apply):

<input type="checkbox"/> Two vehicles	<input type="checkbox"/> Fatality	<input type="checkbox"/> ATV / Snowmobile	<input type="checkbox"/> Train	<input type="checkbox"/> Animal _____
<input type="checkbox"/> More than two vehicles	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Parked vehicle	<input type="checkbox"/> Fixed object _____
	<input type="checkbox"/> Pedestrian		<input type="checkbox"/> Overtaken vehicle	<input type="checkbox"/> Other _____

**Were you covered by liability insurance at the time of the accident?**  YES  NO If you do not complete ALL of this section, your accident will be considered uninsured and your driving privileges may be suspended. You must list the insurance company that provided liability coverage for the vehicle you were driving. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX	
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	<input type="checkbox"/> IF ADDRESS CHANGE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE		
<input type="checkbox"/> SAME					
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE		
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER

**Was your vehicle's damage:**  more than \$1000 or  \$1000 or less?

Did the accident occur while you were driving your employer's vehicle? .....  YES  NO

Were you driving on your job and being paid for the principal purpose of driving? .....  YES  NO

Were you being paid to drive and/or deliver persons or property? .....  YES  NO

Were you operating a government owned vehicle marked for transporting mail in accordance with government rules?  YES  NO

Were you operating an authorized emergency vehicle? .....  YES  NO

Were you operating a commercial motor vehicle requiring you to have a commercial driver license? .....  YES  NO

a) Were you transporting hazardous material? .....  YES  NO

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX	
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE		
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE		
<input type="checkbox"/> SAME					
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE		
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

NARRATIVE

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, ATTACH A SUPPLEMENTAL REPORT.

**DESCRIBE WHAT HAPPENED:**

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SIGNATURE

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT <b>X</b>	DATE SIGNED
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**YOU INTENDED TO...**

Go straight ahead

Make right turn

Make left turn

Make "U" turn

Back-Up

Enter driveway (also mark left or right turn)

Remain stopped in traffic

Enter parked position

Slow or Stop

Leave driveway (also mark left or right turn)

Start in traffic lane

Leave parked position

Remain parked

Overtake and pass

**YOUR VEHICLE**

Passenger car or van, pickup

Any of the above and trailer

Taxicab

Bus

Other publicly-owned vehicle

Truck tractor & semi-trailer

Farm tractor/farm equipment

Military vehicle

School bus

Other \_\_\_\_\_

Other truck combination

Emergency vehicle

Motorcycle

Motor-scooter/bike

Truck/truck tractor

**WEATHER CONDITIONS**

Clear

Raining

Snowing

Fog

Other

**ROAD SURFACE**

Dry

Wet

Snowy

Icy

Other

**LIGHT CONDITIONS**

Daylight

Dawn or dusk

Darkness (lighted)

Darkness (unlighted)

Other

**YOUR RESIDENCE**

Local resident  
(within 25 miles of accident site)

Residing elsewhere in state

Non-resident of this state:

College student

Military

Temporary job

**YOU WERE HEADED**

North  East

South  West

On: \_\_\_\_\_  
(name of street, road or route)

**OTHER DRIVER WAS HEADED**

North  East

South  West

On: \_\_\_\_\_  
(name of street, road or route)

Were occupants of the other vehicle(s) injured?  YES  NO

Did a police officer come to the scene?  YES  NO

If yes, name of police department: \_\_\_\_\_

City  County  State Police

Was a citation issued to you?  YES  NO

**If this accident involved a pedestrian or bicyclist, complete the following:**

**PEDESTRIAN / BICYCLIST NAME**

\_\_\_\_\_

Pedestrian or bicyclist was going:

N  S  E  W

**ALONG OR ACROSS:** (name of street, road or route)

\_\_\_\_\_

**From:**

\_\_\_\_\_

**To:**

\_\_\_\_\_

**WITNESS INFORMATION:**

\_\_\_\_\_

\_\_\_\_\_

**DRIVER AND PASSENGER INJURY AND SAFETY EQUIPMENT INFORMATION**

**SAFETY EQUIPMENT CODES**

WRITE (in column C)

0 No seat belt available

1 Seat belt available but NOT used

2 Seat belt available and in use

3 Child restraint device available

4 Child restraint device in use

5 Helmet NOT in use

6 Helmet in use

7 Air bag deployed

8 Air bag available - NOT deployed

9 Air bag NOT available

**INJURY CODE FOR OCCUPANTS**

WRITE (in column D)

1 Dead as a result of the accident

2 Incapacitated - unconscious, could not walk, broken or distorted limbs, etc.

3 Visible injury - lump, abrasion cuts

4 Momentary unconsciousness, complaint of pain, nausea, limping

5 No apparent injury

EXAMPLE: (From: NE corner To: SE corner (or) From: East side To: West side, etc.)

**Sex and age of pedestrian / bicyclist:**

Male  Female Age: \_\_\_\_\_

**Extent of pedestrian / bicyclist injury:**

Dead  Possible injury

Incapacitated  No apparent injury

Visible injury

**Pedestrian / bicyclist action: (mark one)**

Crossing at intersection or crosswalk

Crossing **not** at intersection or crosswalk

Walking / riding in roadway with traffic

Walking / riding in roadway **against** traffic

Standing in roadway

Pushing or working on vehicles in roadway

Other working in road

Playing in road

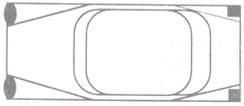
Hitchhiking

Not in roadway

Other \_\_\_\_\_  
(specify)

SEAT POSITION	PASSENGER'S NAMES (your vehicle)	A		B		C		D
		SEX	AGE	SFTY EQP	AIR BAG	INJURY		
DRIVER								
FRONT CENTER								
FRONT RIGHT								
REAR LEFT								
REAR CENTER								
REAR RIGHT								

**Vehicle Damage**



USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)

Vehicle towed

Rollover

Under car

Totaled

Unknown

**Diagram**

Number each vehicle:  

Show path by: 

Show pedestrian by: 

Show railroad tracks by: 

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (name of street, road or route) 

\_\_\_\_\_ (name of street, road or route) 



# INSURANCE VERIFICATION REQUEST

ACCIDENT DATE	DAY OF WEEK M T W T H F S S N	TIME OF DAY AM PM	COUNTY	<b>DO NOT WRITE IN THIS SPACE</b>	Accident Number _____
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)			MILE POST		Accident Type Code (Circle One) 1 2 3 4 6 8 9 X R P
<input type="checkbox"/> WITHIN _____ FEET N S E W	NAME OF NEAREST INTERSECTING ROAD			<input type="checkbox"/> WITHIN _____ FEET N S E W	NAME OF NEAREST CITY / TOWN
<input type="checkbox"/> NEAR _____ MILES N S E W				<input type="checkbox"/> NEAR _____ MILES N S E W	
<b>TYPE OF ACCIDENT</b> - The accident involved one or more of the following: (Mark all that apply):					
<input type="checkbox"/> Two vehicles	<input type="checkbox"/> Fatality	<input type="checkbox"/> ATV / Snowmobile	<input type="checkbox"/> Train	<input type="checkbox"/> Animal _____	
<input type="checkbox"/> More than two vehicles	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Parked vehicle	<input type="checkbox"/> Fixed object _____	
	<input type="checkbox"/> Pedestrian		<input type="checkbox"/> Overturned vehicle	<input type="checkbox"/> Other _____	
<b>Were you covered by liability insurance at the time of the accident?</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">If you do not complete ALL of this section, your accident will be considered uninsured and your driving privileges may be suspended. You must list the insurance company that provided liability coverage for the vehicle you were driving. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.</span>					
DRIVER'S NAME (LAST, FIRST, MIDDLE)		DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH
DRIVER'S ADDRESS		CITY	STATE	ZIP CODE	<input type="checkbox"/> IF ADDRESS CHANGE
VEHICLE OWNER'S NAME AND ADDRESS		CITY	STATE	ZIP CODE	
<input type="checkbox"/> SAME					
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS		CITY	STATE	ZIP CODE	
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER		VEHICLE PLATE NUMBER	STATE	YEAR MAKE & MODEL

## INSTRUCTIONS TO INSURANCE COMPANY

1. If the accident described above was not covered by liability insurance as indicated, check reason below and return this form dated and signed to the address below.
2. If indicated coverage was in effect at the time of the accident no action is required.

## REASON FOR DENIAL:

- Coverage does not meet minimum Oregon liability requirements (\$25,000 — \$50,000 — \$10,000)
- Policy Expired Before Accident
- Policy Effective After Accident
- Vehicle Not Covered on Policy
- Policy Number Given is Incorrect
- Lapse in Policy
- Driver Not Authorized to Operate Vehicle
- Driver Authorized But Not Covered on Policy

PRINTED NAME OF AUTHORIZED REPRESENTATIVE	SIGNATURE <b>X</b>	DATE OF DENIAL
PHONE NUMBER	FAX NUMBER	CLAIM NUMBER

ACCIDENT REPORTING UNIT  
 DRIVER AND MOTOR VEHICLE SERVICES  
 1905 LANA AVENUE NE  
 SALEM OR 97314



# OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Complete this form ONLY if your accident is reportable under Oregon Law. The accident is reportable if it happened on a highway or premises open to the public, and resulted in any of the following: 1) More than \$1000 in damage to any one person's property; 2) Injury to any person (no matter how minor the injury); or, 3) the death of any person. (PLEASE PRINT)

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY	<b>DO NOT WRITE IN THIS SPACE</b>	Accident Number _____
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)			MILE POST		Accident Type Code (Circle One) 1 2 3 4 6 8 9 X R P
<input type="checkbox"/> WITHIN _____ FEET N S E W			NAME OF NEAREST INTERSECTING ROAD	<input type="checkbox"/> WITHIN _____ FEET N S E W	
<input type="checkbox"/> NEAR _____ MILES N S E W				<input type="checkbox"/> NEAR _____ MILES N S E W	

**TYPE OF ACCIDENT** - The accident involved one or more of the following: (Mark all that apply):

<input type="checkbox"/> Two vehicles	<input type="checkbox"/> Fatality	<input type="checkbox"/> ATV / Snowmobile	<input type="checkbox"/> Train	<input type="checkbox"/> Animal _____
<input type="checkbox"/> More than two vehicles	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Parked vehicle	<input type="checkbox"/> Fixed object _____
	<input type="checkbox"/> Pedestrian		<input type="checkbox"/> Overturned vehicle	<input type="checkbox"/> Other _____

Were you covered by liability insurance at the time of the accident?  YES  NO If you do not complete ALL of this section, your accident will be considered uninsured and your driving privileges may be suspended. You must list the insurance company that provided liability coverage for the vehicle you were driving. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	<input type="checkbox"/> IF ADDRESS CHANGE
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
<input type="checkbox"/> SAME				
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE	
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR
				MAKE & MODEL

Was your vehicle's damage:  more than \$1000 or  \$1000 or less?

Did the accident occur while you were driving your employer's vehicle? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you driving on your job and being paid for the principal purpose of driving? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you being paid to drive and/or deliver persons or property? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you operating a government owned vehicle marked for transporting mail in accordance with government rules? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you operating an authorized emergency vehicle? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you operating a commercial motor vehicle requiring you to have a commercial driver license? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a) Were you transporting hazardous material? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
<input type="checkbox"/> SAME				
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE	
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR
				MAKE & MODEL

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, ATTACH A SUPPLEMENTAL REPORT.

**DESCRIBE WHAT HAPPENED:**

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I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT <b>X</b>	DATE SIGNED
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# SUPPLEMENTAL REPORT OREGON TRAFFIC ACCIDENT

Supplemental for more than two drivers involved in the crash.  
Attach this form to your OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT.

ACCIDENT DATE	M T W TH F S SN	TIME OF DAY	AM PM	COUNTY	<b>DO NOT WRITE IN THIS SPACE</b>
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)				MILE POST	

<b>VEHICLE #3</b>	INSURANCE COMPANY NAME AND POLICY NUMBER				
VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL	
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY		STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY		STATE	ZIP CODE	
<input type="checkbox"/> SAME					

<b>VEHICLE #4</b>	INSURANCE COMPANY NAME AND POLICY NUMBER				
VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL	
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY		STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY		STATE	ZIP CODE	
<input type="checkbox"/> SAME					

<b>VEHICLE #5</b>	INSURANCE COMPANY NAME AND POLICY NUMBER				
VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL	
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY		STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY		STATE	ZIP CODE	
<input type="checkbox"/> SAME					

<b>VEHICLE #6</b>	INSURANCE COMPANY NAME AND POLICY NUMBER				
VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL	
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY		STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY		STATE	ZIP CODE	
<input type="checkbox"/> SAME					

<b>VEHICLE #7</b>	INSURANCE COMPANY NAME AND POLICY NUMBER				
VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL	
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	SEX
DRIVER'S ADDRESS	CITY		STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY		STATE	ZIP CODE	
<input type="checkbox"/> SAME					

# POLICE TRUCK/BUS CRASH SUPPLEMENTAL

Do not complete this form unless: One or more qualifying vehicles was involved and met the threshold.

FATAL    INJURY    TOWAWAY    16 OR MORE PASSENGER CAPACITY    10,001 LBS. OR MORE (GVWR)    HAZARDOUS MATERIAL PLACARD

POLICE INCIDENT / CASE NUMBER \_\_\_\_\_ CRASH DATE M T W TH F S SN \_\_\_\_\_ CRASH TIME \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ ROAD ON WHICH CRASH OCCURRED \_\_\_\_\_

COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### VEHICLE INFORMATION

VEHICLE PLATE NUMBER \_\_\_\_\_ State \_\_\_\_\_ Plate Number \_\_\_\_\_

GROSS VEHICLE WEIGHT RATING: (normally located inside driver door)

Truck, Tractor or Bus \_\_\_\_\_

Trailer or Trailers Total \_\_\_\_\_

Total Number of Axles (including Trailers) \_\_\_\_\_

Did vehicle have a HAZARDOUS MATERIAL placard? 1.Yes 2.No

If "Yes," enter name or 4 digit number from placard diamond or box (CODE #32): \_\_\_\_\_

Enter 1 Digit Number from bottom of diamond

Was hazardous material (cargo) released from this vehicle? 1.Yes 2.No

Was an inspection done on this vehicle? 1. Yes 2. No

Inspection Number \_\_\_\_\_ Level 1, 2, 3, 4

### SEQUENCE OF EVENTS (for this vehicle)

- |   |   |
|---|---|
| <input type="checkbox"/> 1 2 3 4<br><input type="checkbox"/> RAN OFF ROAD | <input type="checkbox"/> 1 2 3 4<br><input type="checkbox"/> CRASH INVOLVING MOTOR VEHICLE IN TRANSPORT |
| <input type="checkbox"/> JACKKNIFE / SKID                                 | <input type="checkbox"/> CRASH INVOLVING PARKED MOTOR VEHICLE   |
| <input type="checkbox"/> OVERTURN   | <input type="checkbox"/> CRASH INVOLVING TRAIN  |
| <input type="checkbox"/> DOWNHILL RUNAWAY                                 | <input type="checkbox"/> CRASH INVOLVING PEDALCYCLE   |
| <input type="checkbox"/> CARGO LOSS OR SHIFT                              | <input type="checkbox"/> CRASH INVOLVING ANIMAL   |
| <input type="checkbox"/> EXPLOSION OR FIRE                                | <input type="checkbox"/> CRASH INVOLVING FIXED OBJECT   |
| <input type="checkbox"/> SEPARATION OF UNITS                              | <input type="checkbox"/> CRASH INVOLVING OTHER OBJECT   |
| <input type="checkbox"/> CRASH INVOLVING PEDESTRIAN                       | <input type="checkbox"/> OTHER  |

### CARRIER INFORMATION

NAME \_\_\_\_\_

ADDRESS (STREET OR PO BOX NUMBER) \_\_\_\_\_

CITY \_\_\_\_\_

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

IDENTIFICATION NUMBERS None = 0

US DOT \_\_\_\_\_ ICC MC \_\_\_\_\_

### DRIVER INFORMATION

NAME (LAST-FIRST-MIDDLE) \_\_\_\_\_

DRIVER LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_ CLASS \_\_\_\_\_ ENDORSEMENT \_\_\_\_\_ MEDICAL CERTIFICATION EXP. DATE \_\_\_\_\_

### CO-DRIVER INFORMATION

NAME (LAST-FIRST-MIDDLE) \_\_\_\_\_

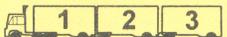
DRIVER LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_ CLASS \_\_\_\_\_ ENDORSEMENT \_\_\_\_\_ MEDICAL CERTIFICATION EXP. DATE \_\_\_\_\_

### DRIVER HOURS RECAP For Certified Inspectors

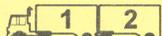
DATE	HOURS ON DUTY	<input type="checkbox"/> FALSE LOG
		<input type="checkbox"/> NO LOG BOOK
		<input type="checkbox"/> DRIVER OUT-OF SERVICE
		<input type="checkbox"/> DRIVER LOG NOT CURRENT
		<input type="checkbox"/> 60/70 HOUR RULE VIOLATION
		<input type="checkbox"/> 10 HOUR RULE VIOLATION
		<input type="checkbox"/> 15 HOUR RULE VIOLATION
		<input type="checkbox"/> CURRENT AND PREVIOUS DAYS LOG NOT IN POSSESSION
		<input type="checkbox"/> FAILURE TO RETAIN 7 PREVIOUS DAYS LOG
		<input type="checkbox"/> LOG VIOLATION-GENERAL
		<input type="checkbox"/> OTHER _____
TOTAL		

### VEHICLE CONFIGURATION

Select Appropriate

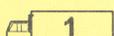
1  Triples (tractor with 3 trailers)

2  Triples (truck with 2 trailers)

3  Doubles (any)

4  Straight Truck-Full Trailer

5  Standard Tractor/SemiTrailer

6  Straight Truck

7  Bobtail

8  Saddlemount

9 Cargo Body Type (circle appropriate type):  
Van Flatbed, Tank, Dump, Belly-Dump, Pole, Garbage, Drop-Box, Auto Carrier, Livestock, Chip, Low-Boy, Mobile Home Toter, Utility, Container, Bulk-Hopper, Fixed Load, Other \_\_\_\_\_

10  Heavy Haul

11  Bus/Van (16 or more passenger capacity)

12  Auto / Pickup

### VEHICLE DAMAGE

Use arrow to show first impact (shade in damaged area).



OFFICER NAME / NUMBER \_\_\_\_\_ DATE \_\_\_\_\_ AGENCY \_\_\_\_\_ APPROVED BY: \_\_\_\_\_



**NOTICE:** IN ADDITION, THE DRIVER MUST FILE AN INDIVIDUAL ACCIDENT REPORT WITH DRIVER AND MOTOR VEHICLE SERVICES (DMV) WITHIN 72 HOURS IF THE ACCIDENT INVOLVED DEATH OR INJURY TO ANY PERSON OR THERE WAS PROPERTY DAMAGE IN THE AMOUNT OF \$1000 OR MORE. THE ACCIDENT REPORTFORM (735-0032) IS AVAILABLE AT ALL DMV & LAW ENFORCEMENT OFFICES OR BY CALLING (503) 945-5098.

# MOTOR CARRIER ACCIDENT REPORT

**INSTRUCTIONS:** IF TWO OR MORE OF THE SCREENING INFORMATION QUESTIONS BELOW ARE ANSWERED "YES", COMPLETE THE ENTIRE FORM AND RETURN IT TO THE ADDRESS LISTED ABOVE.

## SCREENING INFORMATION

<b>QUALIFYING VEHICLE:</b>	COMMERCIAL TRUCK (GVWR OVER 10,000 LBS)?	<input type="checkbox"/>
	HAZARDOUS MATERIAL PLACARD?	<input type="checkbox"/>
	COMMERCIAL BUS (DESIGNED TO CARRY 16 OR MORE PASSENGERS)?	<input type="checkbox"/>
	FARM VEHICLE (4 AXLES OR MORE) OPERATED FOR HIRE (80,000 LBS OR LESS)?	<input type="checkbox"/>
	FARM VEHICLE (4 AXLES OR MORE) OPERATED OVER 80,000 LBS (FARMER'S FARM USE ONLY)?	<input type="checkbox"/>
<b>CRITERIA:</b>	ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE ACCIDENT)?	<input type="checkbox"/>
	ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE?	<input type="checkbox"/>
	ANY VEHICLE TOWED FROM SCENE DUE TO DISABLING DAMAGE?	<input type="checkbox"/>

MOTOR CARRIER NAME		AUTHORITY NO.	
ADDRESS	CITY	STATE	ZIP CODE

## ACCIDENT INFORMATION

PLACE OF ACCIDENT (NEAREST CITY OR TOWN) \_\_\_\_\_ HWY#, MILEPOINT / STREET NAME \_\_\_\_\_ DIRECTION OF YOUR VEHICLE (CIRCLE): **N E S W**

DATE OF ACCIDENT: \_\_\_ / \_\_\_ / \_\_\_ TIME (NEAREST HOUR)  AM  PM DAY OF WEEK (CIRCLE): MON TUE WED THU FRI SAT SUN

## CONDITIONS AT TIME OF ACCIDENT

WEATHER (CIRCLE ONE): 1. CLEAR 2. RAIN 3. SNOW 4. CLOUDY 5. SLEET 6. FOG 7. OTHER \_\_\_\_\_

ROAD SURFACE (CIRCLE ONE): 1. DRY 2. WET 3. SNOWY 4. ICY 5. OTHER \_\_\_\_\_

LIGHT CONDITION (CIRCLE ONE): 1. DAY 2. DAWN 3. DUSK 4. ARTIFICIAL LIGHTS 5. DARK 6. OTHER \_\_\_\_\_

## VEHICLE INFORMATION

YEAR	MAKE	UNIT NO.	PUC PLATE NO.	TOTAL NO. AXLES
_____	_____	_____	_____	_____

VEHICLE TYPE: (CIRCLE ONE) TRUCK, TRUCK-TRAILER, TRAC-TRAILER, TRAC-DBLS, TRAC-TRPLS, TRUCK-2TRLS, BOBTAIL,  
 BUS (IF BUS, NO. OF PASSENGERS ON BOARD: \_\_\_\_\_)

CARGO BODY TYPE: (CIRCLE ONE) VAN, FLATBED, TANKER, CONTAINER, POLE, DUMP, BELLY-DUMP, CAR CARRIER, LIVESTOCK,  
 MOBILE HOME TOWER, PASSENGER, DROP-BOX, GARBAGE, BULK-HOPPER, MIXER, SADDLEMOUNT,  
 WRECKER, FIXED LOAD, HEAVY HAUL UTILITY OTHER \_\_\_\_\_

TOTAL LENGTH OF VEHICLE / COMB	TOTAL WIDTH OF VEHICLE OR CARGO	WEIGHT (CARGO)	WEIGHT (GROSS)
_____	_____	_____	_____

## COMMODITY INFORMATION

COMMODITY BEING TRANSPORTED AT TIME OF ACCIDENT: \_\_\_\_\_

WAS A HAZARDOUS COMMODITY BEING HAULED?  YES  NO WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO? (NOT A FUEL RELEASE)  YES  NO

HAZARD CLASS \_\_\_\_\_

**DRIVER INFORMATION**

DATE OF BIRTH \_\_\_\_\_

NAME OF YOUR DRIVER \_\_\_\_\_

CDL NO. \_\_\_\_\_ STATE \_\_\_\_\_

HOW LONG EMPLOYED AS YOUR DRIVER \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

EXPIRATION DATE OF MEDICAL CERTIFICATE \_\_\_\_\_

FILL OUT THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF ACCIDENT.

AT TIME OF ACCIDENT, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD \_\_\_\_\_

TOTAL HOURS ON DUTY DURING THE PREVIOUS: (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)

7 CONSECUTIVE DAYS \_\_\_\_\_ HOURS

8 CONSECUTIVE DAYS \_\_\_\_\_ HOURS

CONDITION OF DRIVER (CIRCLE ONE): 1. NORMAL 2. HAD BEEN DRINKING

DOES YOUR DRIVER HAVE A MEDICAL WAIVER?  YES  NO

3. ILLEGAL DRUG USE 4. SICK 5. FATIGUE 6. DOZED AT WHEEL

TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.): \_\_\_\_\_

7. OTHER \_\_\_\_\_

**DRIVER INJURY INFORMATION**

YOUR DRIVER KILLED?  YES  NO

YOUR DRIVER INJURED?  YES  NO

RELIEF DRIVER KILLED?  YES  NO

RELIEF DRIVER INJURED?  YES  NO

TOTAL NO. PASSENGERS \_\_\_\_\_ KILLED \_\_\_\_\_ INJURED

**OTHER VEHICLE DRIVER INFORMATION**

(VEH 2) DRIVER NAME \_\_\_\_\_

DRIVER LIC.#, STATE \_\_\_\_\_

YEAR, MAKE, TYPE OF VEHICLE (CAR, TRUCK, BIKE, MOTORCYCLE) \_\_\_\_\_

VEHICLE LIC. # STATE \_\_\_\_\_

(VEH 3) DRIVER NAME \_\_\_\_\_

DRIVER LIC.#, STATE \_\_\_\_\_

YEAR, MAKE, TYPE OF VEHICLE (CAR, TRUCK, BIKE, MOTORCYCLE) \_\_\_\_\_

VEHICLE LIC. # STATE \_\_\_\_\_

**OTHER DRIVER INJURY INFORMATION**

TOTAL NO. OF OTHER DRIVERS \_\_\_\_\_ KILLED \_\_\_\_\_ INJURED

TOTAL NO. OF OTHER PASSENGERS \_\_\_\_\_ KILLED \_\_\_\_\_ INJURED

TOTAL NO. OF PEDESTRIANS \_\_\_\_\_ KILLED \_\_\_\_\_ INJURED

**ACCIDENT INFORMATION**

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. YOUR VEHICLE IS ALWAYS NO. 1. IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 & 3 TO CORRESPOND TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

VEHICLES			ACTION	VEHICLES			ACTION	VEHICLES			ACTION
1	2	3		1	2	3		1	2	3	
			SLOWING-STOPPING				PASSING				JACKKNIFE
			STOPPED				CHANGING LANES				OVERTURN
			REAR-END				SIDESWIPE				SEPARATION OF UNITS
			BACKING				HEAD-ON				FIRE
			MAKING RIGHT TURN				SKIDDING				EXPLOSION
			MAKING LEFT TURN				VEH OUT OF CONTROL				CARGO SHIFT
			MAKING U-TURN				ROLL-AWAY				CARGO SPILL (HAZARDOUS)
			PROCEEDING STRAIGHT				CONTROLLED RR CROSSING				CARGO SPILL (NON-HAZARDOUS)
			INTERSECTION				UNCONTROLLED RR CROSSING				OTHER (DEER, GUARDRAIL, ETC.)
			ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)				RAN OFF ROAD				

DID YOUR VEHICLE STRIKE A PARKED VEHICLE?  YES  NO

WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE?  YES  NO

DESCRIPTION OF ACCIDENT BY CARRIER OFFICIAL: \_\_\_\_\_

TOTAL DAMAGES TO ALL VEHICLES AND PROPERTY: \$ \_\_\_\_\_ TOTAL DAMAGES TO YOUR VEHICLE AND PROPERTY: \$ \_\_\_\_\_

NAME AND TITLE OF PERSON SIGNING REPORT	TELEPHONE NO. ( )
SIGNATURE	DATE