Motor Vehicle Accident Report Form

PHONE #	AGENCY CONTACT INFORMATION	AGENCY

DATE OF ACCIDENT	TIME OF ACCIDENT AM: PM:	LOCATION ACCIDENT OCCURED: ☐ NE ☐ NW ☐ SE ☐ SW ______________________________ ft of ____________________ Street Street	STATE

TYPE OF ACCIDENT (check one)	TRAFFIC CONDITIONS (check one)	TRAFFIC CONTROLS (check one)	ROAD SURFACE (check one)	ROAD CONDITION (check one)
__ 00 Collision of vehicles __ 01 Collision with fixed object __ 02 On board school bus __ 03 Boarding/Alighting __ 04 Pedestrian __ 05 Fatality	__ 00 Unknown __ 01 Heavy __ 02 Medium __ 03 Light	__ 00 Unknown __ 01 Yield Sign __ 02 Signal __ 03 Officer __ 04 Turn Restricted __ 05 Flashing Light __ 06 Stop Sign __ 07 None __ 08 Other __	__ 00 Unknown __ 01 Concrete __ 02 Asphalt __ 03 Light __ 04 Gravel __ 05 Dirt ___06 Other	__ 01 Unknown __ 02 Repairing __ 03 Dry __ 04 Wet __ 05 Ice

ROAD TYPE (check one)	LIGHT CONDITIONS (check one)	STREET LIGHTS (check one)	WEATHER (check ALL that apply)
__ 00 Straight __ 01 Curve __ 02 Level __ 03 Grade __ 04 Crest __ 05 Underpass __ 06 Ramp __ 07 Bridge __ 08 Divided	__ 00 Unknown __ 01 Dawn/Dusk __ 02 Dark __ 03 Daylight	__ 00 Unknown __ 01 Defective street light(s) __ 02 No street light(s) __ 03 Street light(s) on __ 04 Street light(s) off	__ 00 Unknown __ 01 Fog/Midst __ 02 Clear __ 03 Rain __ 04 Snow __ 05 Sleet

Total # of Vehicles Involved: ______________________

District Driver & Vehicle Information

District Vehicle No. ______________ # of Passengers in District Vehicle: _______ # of Passengers Injured in District Vehicle: ________

District Operator (Last Name, First Name, M.I.) Age Sex Full or Part-time (FT or PT) Driver Injured: Yes or No

____ _____ ___ _______________________

Drivers License # ____________________ License State: _______ Home Phone #: ( ) ______- ________ Cell Phone #: ( ) ______- ________

Vehicle Model/Year Make Body Style Tag #/State/Year Vehicle Color Vehicle Damaged: Yes or No

____________________ __________________ ______________ ____________________ _______________

Speed at time of Impact: ________ mph Skid Mark Details: ____

Vehicle Driven Away: Yes or No Vehicle left at scene: Yes or No If towed, to where: ____

DRIVER CONDITION
(check ALL that apply)

__ 00 Fatigued
__ 01 Ill
__ 02 Physical defect
__ 03 Asleep
__ 04 Normal
__ 05 Unknown
__ 06 Ability Impaired
__ 07 Ability not impaired

PRIMARY CAUSE OF ACCIDENT:
Insert ONE code from below for **DISTRICT** vehicle here: ☐ Insert ONE code from below for **CLAIMANT** vehicle here: ☐

__ 00 Speed
__ 01 Defective brakes
__ 02 Signal
__ 03 Auto right of way
__ 04 Pedestrian right of way
__ 05 Improper Turn
__ 06 Yield Sign
__ 07 Stop/Go light
__ 08 Flashing light
__ 09 Directional light
__ 10 Stop Sign
__ 11 Alcohol influence
__ 12 Improper lane change
__ 13 One way street-wrong way
__ 14 Wrong side of street
__ 15 Improper starting
__ 16 Other Defects
__ 17 Pedestrian Violation
__ 18 Driver inattention
__ 19 Cell Phone
__ 20 Failure to set parking brake
__ 21 Opened door in traffic
__ 22 Drug influence
__ 23 Backing
__ 22 Defective light(s)
__ 23 Pedestrian drunk
__ 24 Road defects
__ 25 Driver vision obstructed
__ 26 Other: ______________
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Claimant Information

Claimant (Last Name, First Name, M.I.) ______________________ Age ________ Sex ________ Estimated Damage $ ______________

Home Address ______________________ Business Address ______________________

Drivers License #/State _________________ Home Phone #: ( ) ____- ________ Alternate Phone #: ( ) ____- ________

Vehicle Model/Year: ________________________________ Tag #/State/Year: ____________________________________
Make: ____ Vehicle Color: _______________________________________
Body Style: _______________________________________

# of Passengers in Claimant Vehicle: _______ # of Passengers Injured in Claimant Vehicle: ________
Do you have Collision Insurance? ____Yes ___No Amount of Deductible $________________________

Vehicle Damaged: Yes or No Speed at time of Impact: ________ mph Skid Mark Details: ___________________________
Was vehicle driven away? Yes or No Was vehicle left at the scene? Yes or No If towed, to where: _____________________________
Tow Co. Info. _______________________

INJURY CODE (check ALL that apply)
__ 00 Fatal __ 01 Disabling __ 02 Non-disabling __ 03 None
__ 04 Unknown __05 No visible injury __ 06 Complaint of pain/no visual injury

CLAIMANT CONDITION (check one)
__ 00 Fatigued __ 01 Ill __ 02 Physical defect
__ 03 Asleep __ 04 Normal __ 05 Unknown
__ 06 Ability Impaired __ 07 Ability not impaired

TYPE OF VEHICLE (check one):
__ 00 Passenger Auto __ 01 Bus __ 02 Truck __ 03 Trailer __ 04 Unknown __ 05 Taxi __ 06 Motorcycle __ 07 Bicycle
__ 08 Fire engine __ 09 Ambulance __ 10 Fixed Object __ 11 Vendor Cart __ 12 Heavy Equipment __13: Other:_______________

Additional Claimant Information

Claimant (Last Name, First Name, M.I.) ______________________ Age ________ Sex ________ Estimated Damage $ ______________

Home Address ______________________ Business Address ______________________

Drivers License #/State _________________ Home Phone #: ( ) ____- ________ Alternate Phone #: ( ) ____- ________

Vehicle Model/Year: ________________________________ Tag #/State/Year: ____________________________________
Make: ____ Vehicle Color: _______________________________________
Body Style: _______________________________________

# of Passengers in Claimant Vehicle: _______ # of Passengers Injured in Claimant Vehicle: ________
Do you have Collision Insurance? ____Yes ___No Amount of Deductible $________________________

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Vehicle Damaged: Yes or No Speed at time of Impact: ________ mph Skid Mark Details: ___________________________
Was vehicle driven away? Yes or No Was vehicle left at the scene? Yes or No If towed, to where: _____________________________
Tow Co. Info. _______________________

INJURY CODE (check ALL that apply)
__ 00 Fatal __ 01 Disabling __ 02 Non-disabling __ 03 None
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CLAIMANT CONDITION (check one)
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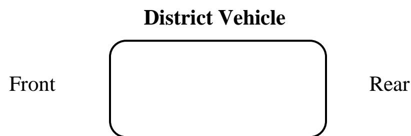
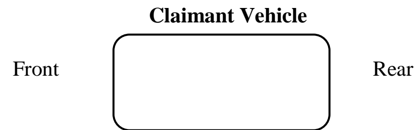
Pedestrian/Vehicle Actions:		Witnesses Information:
___ Unknown	___ With signal in crosswalk	Name Address Phone Number
___ Against signal n crosswalk	___ In crosswalk-no signal	1. ______________________________
___ From between parked cars	___ Backing up	2. ______________________________
___ Turning right	___ Turning left_	3. ______________________________
___ Parked	___ Entering/leaving parking	
___ Making U-Turn	___ Run off Road	
___ Slowing/stopping	___ Overtaking	
___ Changing lanes	___ Going straight	
___ Stopped	___ Avoiding	
___ Other: _________________________		

LOCATION OF ACCIDENT:	**Injured Person(s) Information:**
____ At intersection	Name/Address Phone Number Injuries/Which Vehicle
___ Not at intersection	1.______________________________
___ At crosswalk	2.______________________________
___ Not at crosswalk	3. ______________________________
___ Other:_____________________	

INDICATE AREA OF DAMAGE TO VEHICLES BELOW:





Description of Accident:

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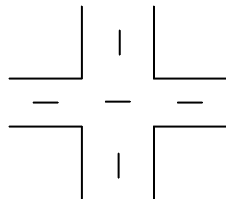

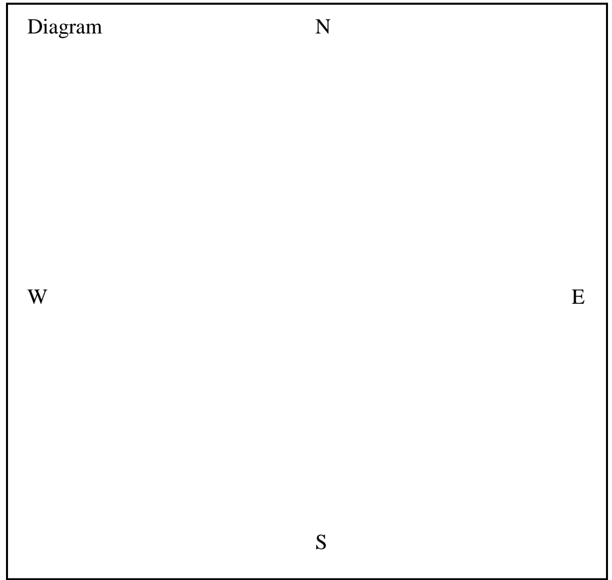

Supervisor at Scene: ____________________________________ Complaint No.: ______________________

Investigating Police Officer: ______________________________ Badge No.: _____________ District/Precinct: ____________

Phone #: ____

Signature of District Driver: ____ Date: ______________________________

ORM-TRT-MV-001
(Revised 01/09)

FAX COMPLETED FORM TO: (202) 727-0249