

**Date of Accident:** \_\_\_\_\_ **Time:** \_\_\_\_\_  Am.  Pm.

<b>Vehicle #1 / Company Equipment</b>	Driver's Name				Age	Position			
	Business Address			Zip	Phone			Was vehicle being used on Job Duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Operator's License #	License Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, indicate			Have you had a previous accident on this company while driving? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	License No.	Year	Body Type	Where Located			No. of Passengers	Est. Repair Cost	
	Describe Damages Fully (Parts, type and extent of damage)								
	If Privately Owned, Name and Address of Owner (If Company Owned, Equipment No. Only)								
<b>Others Vehicles Involved</b>	Owner Car No. 2			Phone		Owner Car No. 3			Phone
	Address		City	Zip		Address		City	Zip
	Driver's Name		Age	Phone		Driver's Name		Age	Phone
	Address		City	Zip		Address		City	Zip
	Driver's License No.		Vehicle License No.		Driver's License No.		Vehicle License No.		
	Vehicle Make	Year	Body Type		Vehicle Make	Year	Body Type		
	Name Of Passengers				Name Of Passengers				
	Repair Cost	Describe Damage			Repair Cost	Describe Damage			
	Insurance Company		Policy No.		Insurance Company		Policy No.		
	<b>Other Property</b>	What was Damaged						Repair cost	
Name and Address of Owner						City	Zip	Phone	
<b>Injured Parties</b>	Name and Address			Extent of Injury	Age	Veh.1	Veh.2	Veh.3	Ped.
<b>WITNESSES</b>	Name		Address		City	Zip	Phone		

# [VEHICLE / EQUIPMENT ACCIDENT & PROPERTY DAMAGE REPORT]

Fill Out Completely

<b>Other Reports</b>	Police Investigate? <input type="checkbox"/> Yes <input type="checkbox"/> No	With Division (Sheriff, Hwy. P., City)	Citation Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No Issued to: <input type="checkbox"/> You <input type="checkbox"/> Veh. 2 <input type="checkbox"/> Veh. 3
	Location		Or Near Intersection of

City/County	Type of Accident
	<input type="checkbox"/> Front to Rear <input type="checkbox"/> Head-On <input type="checkbox"/> Parked Car <input type="checkbox"/> Pedestrian <input type="checkbox"/> Broadside <input type="checkbox"/> Sideswipe <input type="checkbox"/> Bike-Car <input type="checkbox"/> Hit Object

Information Regarding Accident	No. 1, Your Vehicle	No. 2 Other Party (Name)	No. 3 Other Party (Name)
1. If pedestrian where was he/she (crosswalk, etc.)?			
2. Road conditions (dry, glare, icy rain, snow, etc.)? (Gravel, blacktop, etc.)			
3. At what distance was danger first noticed?			
4. Speeds at time danger was first noticed?			
5. Speeds at time of accident?			
6. What warning signals were given?			
7. Obstruction to vision (weather and other)?			
8. Lights On? Wipers On? Windows Fogged?			
9. Had any Party been drinking/drug/Impaired? Who?			

Describe in Detail What Happened (Use additional paper if necessary)

<input type="checkbox"/> Straight Road <input type="checkbox"/> Curve - R or L <input type="checkbox"/> Level  <input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill  <input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;"><b>Mark Damaged Areas</b></p> </div>
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Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

**IMPORTANT**  
If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass  
N. E. S. W.

Signature Driver	Date	Signature Supervisor	Date
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