

PERSONAL REPORT OF ACCIDENT

This form should be completed when a traffic accident occurs and a law enforcement officer is not called to make a report. **This report is for your personal use and should not be mailed to the Department of Driver Services, as it will be destroyed upon receipt.**

INSTRUCTIONS:

1. Answer all questions to the best of your knowledge. If unable to answer any questions, mark "not known".
2. Give exact time of accident (date, day and hour).
3. Under "Location of Accident" show sufficient information to locate exact scene of the accident.
4. Print or type all names and addresses.
5. Sign the report in the space provided on the reverse side.
6. Report must be complete as to exact names, birth dates, and drivers license numbers.
7. Use a second report form or a sheet of plain paper of the same size to report additional vehicles, injured persons, or witnesses, or any other information for which there is insufficient space.

Time	Date of Accident _____		Day of Week _____		Hour _____ A.M. _____ P.M.		Weather _____ (Clear, Raining, Fog, Etc.)		DO NOT WRITE IN THIS SPACE
LOCATION	Place Where Accident Occurred: County _____ City, Town Or Township _____								
	If accident was outside city limits indicate distance from nearest town. Use two distances and two directions if necessary. { _____ miles _____ south-north } of { <input type="checkbox"/> limits of <input type="checkbox"/> center of } _____ City or Town { _____ miles _____ east-west } ROAD ACCIDENT OCCURRED ON: _____ Give name of street or highway number, (U.S. or State). If no highway number, identify by name. <input type="checkbox"/> At its intersection with: _____ Name of intersecting street or highway number Check and complete one OR <input type="checkbox"/> Not at intersection: { _____ feet _____ south-north } of _____ show nearest intersecting street or highway, house number, bridge, driveway or other identifying landmark. { _____ feet _____ east-west }								
VEHICLES	YOUR VEHICLE NUMBER 1								
	Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____		Vehicle License Plate _____		Year _____ State _____ Number _____		Approximate cost to repair vehicle _____		
	Driver _____ Full Name _____		Street _____		City and State _____				
	Driver's Occupation _____ Carpenter, Sales Clerk, Etc.		Driver's License _____ State _____ Number _____		Driver's Birth Date _____ Age _____ Sex _____				
	Owner _____ Full Name _____		Street _____		City and State _____		Owner's Birth Date _____ Mo. _____ Da. _____ Yr _____		
	Parts of Vehicle Damaged _____		Driveable <input type="checkbox"/> Yes <input type="checkbox"/> No		Owner's Driver License _____				
	Is this vehicle covered by automobile liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES TO EITHER SHOW INSURANCE COMPANY Name _____		State Number _____				
	If vehicle not covered, did driver have liability policy applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No		Show Policy Number Here _____		Address _____				
Space for any third vehicle on reverse side. Total vehicles involved	OTHER VEHICLE NUMBER 2								
	Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____		Vehicle License Plate _____		Year _____ State _____ Number _____		Approximate cost to repair vehicle _____		
	Driver _____ Full Name _____		Street _____		City and State _____				
	Driver's Occupation _____ Carpenter, Sales Clerk, Etc.		Driver's License _____ State _____ Number _____		Driver's Birth Date _____ Age _____ Sex _____				
	Owner _____ Full Name _____		Street _____		City and State _____		Owner's Birth Date _____ Mo. _____ Da. _____ Yr _____		
	Parts of Vehicle Damaged _____		Driveable <input type="checkbox"/> Yes <input type="checkbox"/> No		Owner's Driver License _____				
	Is this vehicle or driver covered by automobile liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes show name of Insurance Company _____		State Number _____				
DAMAGE TO PROPERTY OTHER THAN VEHICLE _____		NAME OBJECT AND STATE NATURE OF DAMAGE _____					Approximate cost to repair \$ _____		
NAME AND ADDRESS OF OWNER OF DAMAGED PROPERTY _____									

3rd VEHICLE

Vehicle No. 3 (If third vehicle Involved) _____ Vehicle _____ Approximate cost
License Plate _____ to repair vehicle _____
Year Make Type (sedan, truck, taxi, bus, etc.) Year State Number

Driver _____
Full Name _____ Street _____ City and State _____

Driver's _____
Occupation _____ Driver's License _____ Birth Date _____ Age _____ Sex _____
Carpenter, Sales Clerk, Etc. State Number Mo. Da Yr

Owner _____
Full Name _____ Street _____ City and State _____ Owner's Birth Date _____
Parts of _____
Vehicle Damaged _____ Driveable ☐ Yes ☐ No Driver License _____
State _____ Number _____

Is this vehicle or driver covered by automobile liability insurance? ☐ Yes ☐ No If Yes show name of Insurance Company _____

INJURED

Total Injured

Name _____ Address _____ ☐ Driver In Vehicle
☐ Passenger No. _____
Age _____ Sex _____ Race _____ Injured taken to _____ ☐ Pedestrian
Did injured die? _____ Nature and extent of injuries _____ Attending Doctor _____
☐ Specify other _____

Name _____ Address _____ ☐ Driver In Vehicle
Age _____ Sex _____ Race _____ Injured taken to _____ ☐ Passenger No. _____
☐ Pedestrian
Did injured die? _____ Nature and extent of injuries _____ Attending Doctor _____
☐ Specify other _____

Light Conditions

- ☐ Daylight
☐ Dawn or Dusk
☐ Darkness

What Pedestrian Was Doing

Pedestrian was going ☐ ☐ ☐ ☐ ☐ Across or into _____ From _____ To _____
N S E W Street name, highway no.

☐ Crossing or entering at intersection ☐ Walking in roadway-with traffic ☐ Pushing or working on vehicle ☐ Other in roadway

☐ Crossing or entering not at intersection ☐ Walking in roadway-against traffic ☐ Other working in roadway ☐ Not in roadway

☐ Getting on or off vehicle ☐ Standing in roadway ☐ Playing in roadway

What Drivers Intended To Do: (Check one for each driver)

Driver 1 2 3	Driver 1 2 3	Driver 1 2 3	Driver 1 2 3
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Go straight ahead	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make Left Turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start in Traffic	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain stopped in traffic lane
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overtake and pass	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make U Turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start from parked position	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain Parked
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make right turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make right turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Get out of parked or stopped vehicle

Witnesses:

Name _____ Address _____ Age _____
Name _____ Address _____ Age _____
approximate
approximate

DESCRIBE WHAT HAPPENED:

Refer to vehicles by number. If more space is needed, use another report form or a sheet of plain paper of the same size.

Signature _____ Address _____ Date _____
Signature of person submitting report is required. Complete both sides of this form.