



# OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

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

**ONLY drivers involved in an accident resulting in any of the following MUST file an *Accident & Insurance Report*:**

- Damage to your vehicle is over \$1500
- Injury (No matter how minor)
- Death
- Damage to any one person's property over \$1500
- Any vehicle has damage over \$1500 and any vehicle is towed from the scene as a result of damages

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 and Insurance 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 those drivers required to report, unless the vehicle is parked. If you have questions, please call the Accident Unit at (503) 945-5098.

## INSTRUCTIONS

**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 attached *Supplemental Report* (Form 735-32B), or on a blank piece of paper, write all the information as requested in Section 4, 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.

## SECTION 1

**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.

## SECTION 2

**YOUR VEHICLE (# 1)** — DMV will consider your accident uninsured if you do not complete **ALL** of this section. You must list the insurance company name (not agency) and policy number 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.

## SECTION 3

Answer all of the questions in Section 3. 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. Property includes, but is not limited to, fixed or real property, landscaping, signs, parked vehicles, and animals.

**NOTE TO COMMERCIAL MOTOR VEHICLE OPERATORS:** In addition to this report, Oregon Administrative Rule requires that Form 735-9229, *Motor Carrier Crash 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 disabling damage. Form 735-9229 (attached on back) **MUST** be submitted with *Oregon Traffic Accident and Insurance Report* (Form 735-32) to DMV. For questions regarding the *Motor Carrier Crash Report*, call (503) 986-3507.

## SECTION 4

**OTHER VEHICLE (# 2)** — Completion of this information will help DMV match all driver's accident reports more efficiently. If additional vehicles were involved in the accident, complete attached *Supplemental Report* (Form 735-32B).

## SECTION 5

**DESCRIPTION AND SIGNATURE** — Describe what happened. It is important for you to sign and date the form.

## COMPLETING AND FILING REPORT

**OTHER SIDE OF FORM** — Complete the other side of the form. Information collected from both sides of this form is used by DMV and other officials in making valuable transportation decisions about the roadway systems and driver safety.

**YOUR COPY** — Under Oregon law ORS 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, bring the form, with the PINK copy, to a DMV office and 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.

# 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 or 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 (banks or 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 *Application for Salvage Title* (Form 735-229) from any DMV office, by calling (503) 945-5000, or on-line at [www.oregondmv.com](http://www.oregondmv.com). Application instructions and fee information are on the back of the form 735-229. 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 BOTH SIDES

Complete this form ONLY if your accident happened on a highway or premises open to the public, and resulted in any of the following: 1) More than \$1500 in damage to your vehicle; 2) More than \$1500 in damage to any one person's property other than a vehicle; 3) Any vehicle has more than \$1500 and any vehicle is towed from the scene as a result of damages; 4) Injury to any person (no matter how minor the injury); or, 5) the death of any person.

<b>SECTION 1</b>	ACCIDENT DATE	DAY OF WEEK M T W TH 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	<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"/> ATV / Snowmobile <input type="checkbox"/> Parked vehicle <input type="checkbox"/> More than two vehicles <input type="checkbox"/> Motorcycle <input type="checkbox"/> Overturned vehicle <input type="checkbox"/> Fatality <input type="checkbox"/> Motorized Scooter <input type="checkbox"/> Animal <input type="checkbox"/> Bicycle <input type="checkbox"/> Personal (assisted) mobility device <input type="checkbox"/> Fixed object / property <input type="checkbox"/> Pedestrian <input type="checkbox"/> Train <input type="checkbox"/> Other _____
	<input type="checkbox"/> WITHIN _____ FEET N S E W		NAME OF NEAREST INTERSECTING ROAD				
	<input type="checkbox"/> NEAR _____ MILES N S E W						
<input type="checkbox"/> WITHIN _____ FEET N S E W		NAME OF NEAREST CITY / TOWN					
<input type="checkbox"/> NEAR _____ MILES N S E W							

**Complete ALL of this section.** If you fail to do so, your driving privileges may be suspended. You **MUST** list the insurance company (not agency) and policy number that provided liability coverage for the vehicle you were driving.

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

**Check all statements that apply:**

- Damage to your vehicle was more than \$1500.
- Damage to any one person's property (other than vehicle) was more than \$1500.
- Your vehicle was towed from the scene as a result of damages.
- You or passengers in your vehicle were injured.
- The accident occurred while you were driving your employer's vehicle.
- You were driving on your job and being paid for the principal purpose of driving.
- You were being paid to drive and/or deliver persons or property.
- You were operating a government owned vehicle marked for transporting mail in accordance with government rules.
- You were operating an authorized emergency vehicle.
- You were operating a commercial motor vehicle requiring you to have a commercial driver license.
  - You were transporting hazardous material.
- A police officer came to the scene.  
Name of police department: \_\_\_\_\_  City  County  State Police
- A citation was issued to you.  
The citation was: \_\_\_\_\_

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					
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, USE ATTACHED SUPPLEMENTAL REPORT (Form 735-32B).

**SECTION 5**

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>	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE # ( )	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, pickup, van

Military vehicle

Taxicab

Emergency vehicle

Any of the above and trailer

Private or public agency transit vehicle

Bus

School bus

Other publicly-owned veh.

Motorcycle

Motor-scooter/bike

Personal (assisted) mobility device

Truck tractor & semi trailer

Truck/truck tractor

Other truck combination

Farm tractor/farm equip.

**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)

**WITNESS INFORMATION:**

\_\_\_\_\_

\_\_\_\_\_

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

PEDESTRIAN NAME  BICYCLIST NAME

Pedestrian or bicyclist was going:

N  S  E  W

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

From:

To:

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

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

**SAFETY EQUIPMENT CODES**  
WRITE one of the codes (0-10) 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 Child restraint device not available

6 Helmet NOT in use

7 Helmet in use

8 Air bag deployed

9 Air bag available - NOT deployed

10 Air bag NOT available

**INJURY CODE FOR OCCUPANTS**  
WRITE one of the codes (1-5) in column D

1 Deceased 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

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

\* Use only for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

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

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

**Extent of pedestrian / bicyclist injury:**

Deceased  Momentary unconsciousness /complaint of pain

Incapacitated

Visible injury  No apparent 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

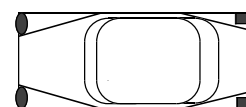
Playing in road

Hitchhiking

Not in roadway

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

**Vehicle Damage**

FRONT 

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

Vehicle towed

Rollover

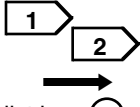
Under car

Totaled


Unknown

Your Vehicle (No. 1) damage: \$ \_\_\_\_\_.

**Diagram**

Number each vehicle: 

Show path by: \_\_\_\_\_

Show pedestrian/bicyclist by: 

Show railroad tracks by: =====

\_\_\_\_\_

\_\_\_\_\_

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

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

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



# 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	DAY OF WEEK 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 (NOT AGENCY)	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 <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	

<b>VEHICLE #4</b>	INSURANCE COMPANY NAME (NOT AGENCY)	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 <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	

<b>VEHICLE #5</b>	INSURANCE COMPANY NAME (NOT AGENCY)	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 <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	

<b>VEHICLE #6</b>	INSURANCE COMPANY NAME (NOT AGENCY)	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 <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	

<b>VEHICLE #7</b>	INSURANCE COMPANY NAME (NOT AGENCY)	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 <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	

# MOTOR CARRIER CRASH REPORT

**INSTRUCTIONS:** IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN AND A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE REMAINDER OF THE MOTOR CARRIER CRASH REPORT AND SUBMIT TO THE ADDRESS SHOWN ABOVE. IF NO CIRCUMSTANCES LISTED UNDER THE CRITERIA COLUMN APPLY, YOU ARE NOT REQUIRED TO SUBMIT THE MOTOR CARRIER CRASH REPORT. IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER CRASH REPORT, PLEASE CALL (503) 986-3507.

<b>QUALIFYING VEHICLE</b> <input type="checkbox"/> COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF CRASH EVEN IF GVWR IS SET UNDER 10,000 LBS ) <input type="checkbox"/> HAZARDOUS MATERIAL PLACARD <input type="checkbox"/> COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS) <input type="checkbox"/> FARM TRUCK INTERSTATE (OVER 10,000 LBS.) <input type="checkbox"/> FARM TRUCK FOR-HIRE (4 OR MORE AXLES) <input type="checkbox"/> FARM TRUCK TOWING TRIPLE TRAILERS <input type="checkbox"/> FARM TRUCK (OVER 80,000 LBS.)		<b>CRITERIA</b> <input type="checkbox"/> 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 INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE	
MOTOR CARRIER NAME		US DOT NUMBER	AUTHORITY/FILE NUMBER
ADDRESS		CITY	STATE ZIP CODE

## DRIVER INFORMATION

DRIVER NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	LENGTH OF EMPLOYMENT YEARS MONTHS
CDL /DL NUMBER	STATE	LICENSE CLASS <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> M	EXPIRATION DATE OF MEDICAL CERTIFICATE

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

AT TIME OF THE 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 _____ 8 CONSECUTIVE DAYS _____
DOES YOUR DRIVER HAVE A MEDICAL WAIVER <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)

## DRIVER INJURY INFORMATION

YOUR DRIVER KILLED <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR DRIVER INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO	RELIEF DRIVER KILLED <input type="checkbox"/> YES <input type="checkbox"/> NO	RELIEF DRIVER INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO	TOTAL NUMBER OF PASSENGERS ____ KILLED ____ INJURED
--------------------------------------------------------------------------------	---------------------------------------------------------------------------------	----------------------------------------------------------------------------------	-----------------------------------------------------------------------------------	--------------------------------------------------------


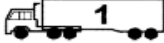

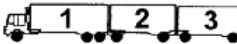
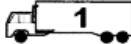




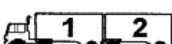

## OTHER DRIVER INJURY INFORMATION

TOTAL NUMBER OF OTHER DRIVERS ____ KILLED ____ INJURED	TOTAL NUMBER OF OTHER PASSENGERS ____ KILLED ____ INJURED	TOTAL NUMBER OF PEDESTRIANS ____ KILLED ____ INJURED	TOTAL NUMBER OF BICYCLISTS ____ KILLED ____ INJURED
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## OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

MOTOR CARRIER NAME	VEHICLE LICENSE # AND STATE	DRIVER'S NAME	DRIVER'S LICENSE # AND STATE

## MOTOR CARRIER VEHICLE INFORMATION

YEAR	MAKE	UNIT NUMBER	TRUCK/TRACTOR/BUS LICENSE PLATE NO. & STATE	TOTAL NO. OF AXLES INCLUDING TRAILERS	
VEHICLE TYPE (SELECT APPROPRIATE TYPE)					
<input type="checkbox"/> 1	 Triples (tractor with 3 trailers)	<input type="checkbox"/> 5	 Standard Tractor/Semi Trailer	<input type="checkbox"/> 9	 Heavy Haul
<input type="checkbox"/> 2	 Triples (truck with 2 trailers)	<input type="checkbox"/> 6	 Straight Truck	<input type="checkbox"/> 10	 Bus/Van (8 or more passenger capacity)
<input type="checkbox"/> 3	 Straight truck-full trailer	<input type="checkbox"/> 7	 Bobtail	<input type="checkbox"/> 11	 Auto/Pickup
<input type="checkbox"/> 4	 Doubles (any)	<input type="checkbox"/> 8	 Saddlemount		

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
TOTAL LENGTH OF VEHICLE/COMB	TOTAL WIDTH OF VEHICLE OR CARGO	CARGO WEIGHT	GROSS VEHICLE WEIGHT

**COMMODITY INFORMATION**

COMMODITY BEING TRANSPORTED AT TIME OF CRASH		
WAS A HAZARDOUS COMMODITY BEING HAULED <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO (NOT A FUEL RELEASE) <input type="checkbox"/> YES <input type="checkbox"/> NO	HAZARD CLASS

**CRASH INFORMATION**

LOCATION OF CRASH (NEAREST CITY OR TOWN)	HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD	DIRECTION OF YOUR VEHICLE (CIRCLE) N    S    E    W
DATE OF CRASH	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	DAY OF THE WEEK (CIRCLE ONE) MON    TUES    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 _____	

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				VEHICLE 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO
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DESCRIPTION OF ACCIDENT BY CARRIER OFFICIAL

NAME AND TITLE OF PERSON SIGNING REPORT	TELEPHONE NUMBER(S)
SIGNATURE I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE	DATE