

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

Time	any other information for which there is insufficient space. Date of Accident _____ Day of _____ Week _____ Hour _____ A.M. _____ P.M. Weather _____ (Clear, Raining, Fog, Etc.)	DO NOT WRITE IN THIS SPACE
L O C A T I O N	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 } _____ { _____ miles east-west } { <input type="checkbox"/> center of } City or Town ROAD ACCIDENT OCURRED 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 }	
V E H I C L E S	YOUR VEHICLE NUMBER 1 Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____ Driver _____ Driver's Occupation _____ Carpenter, Sales Clerk, Etc. State _____ Owner _____ Parts of Vehicle Damaged _____ Is this vehicle covered by automobile liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If vehicle not covered, did driver have liability policy applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES TO EITHER SHOW INSURANCE COMPANY Name _____ Show name of insurance company not name of insurance agency. Show Policy Number Here _____ Address _____	Vehicle License Plate _____ Approximate cost to repair vehicle _____ Year _____ State _____ Number _____ Street _____ City and State _____ Driver's License Number _____ Driver's Birth Date _____ Age _____ Sex _____ Mo. _____ Da _____ Yr _____ Owner's Birth Date _____ Mo _____ Da _____ Yr _____ Driveable <input type="checkbox"/> Yes <input type="checkbox"/> No Driver License _____ State Number _____
Space for any third vehicle on reverse side. Total vehicles involved	OTHER VEHICLE NUMBER 2 Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____ Driver _____ Driver's Occupation _____ Carpenter, Sales Clerk, Etc. State _____ Owner _____ Parts of Vehicle Damaged _____ 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 _____	Vehicle License Plate _____ Approximate cost to repair vehicle _____ Year _____ State _____ Number _____ Street _____ City and State _____ Driver's License Number _____ Driver's Birth Date _____ Age _____ Sex _____ Mo. _____ Da _____ Yr _____ Owner's Birth Date _____ Mo _____ Da _____ Yr _____ Driveable <input type="checkbox"/> Yes <input type="checkbox"/> No Driver License _____ 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 _____		

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Vehicle No. 3 (If third vehicle Involved) _____ Vehicle License Plate _____ Approximate cost to repair vehicle _____
 Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____ Year _____ State _____ Number _____
 Driver _____ Full Name _____ Street _____ City and State _____
 Driver's Occupation _____ Carpenter, Sales Clerk, Etc. _____ State _____ Driver's License 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 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 _____

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D
Total Injured

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

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 _____ approximate
 Name _____ Address _____ Age _____ 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.