



OREGON TRAFFIC CRASH AND INSURANCE REPORT

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

ONLY drivers involved in a crash resulting in any of the following MUST file a *Crash & Insurance Report*:

- Damage to your vehicle is over \$2500
- Injury (No matter how minor)
- Death
- Damage to any one person's property over \$2500
- Any vehicle has damage over \$2500 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 crash. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the crash 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 Crash and Insurance Report with DMV. When required to report, even if you are licensed in another state, or you are not an Oregon resident, you still must file a report with Oregon DMV.** DMV does not determine fault in a crash, but does post the crash to the driving record of those drivers required to report, unless the vehicle is parked. **If you have questions, please call DMV Crash Reporting 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 crash, 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.
- 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 crash. The correct date, location and time are critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

SECTION 2

Your vehicle is Vehicle #1. Complete ALL fields. **Provide Insurance company name (not agent), policy number, and Vehicle identification number (VIN).** Failure to provide complete insurance and vehicle information may result in DMV issuing Notice of Suspension due to incomplete information.

SECTION 3

Failure to complete this section may result in DMV sending Notice of Suspension for failure to file a report. Principle purpose of driving and being paid to drive does not mean 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.

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 crash 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 Crash and Insurance Report* (Form 735-32) to DMV. Call (503) 986-3507 for questions regarding the *Motor Carrier Crash Report*.

[You may now file the Motor Carrier Crash Report at: www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/](http://www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/)

SECTION 4

OTHER VEHICLE (# 2) — Completion of this information will help DMV match all driver's crash reports more efficiently. If additional vehicles were involved in the crash, 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. Only a family member may sign and date this form on behalf of a driver when the driver is incapacitated or physically unable to sign. No other signatures will be accepted.

COMPLETING AND FILING REPORT

HOW TO SUBMIT A REPORT TO DMV:

- Fax to 503-945-5267
- Mail to DMV Crash Reporting Unit 1905 Lana Ave NE, Salem, Oregon 97314
- Deliver to a DMV office

Keep a copy of the report and documentation that shows when you submitted your report to Oregon DMV. Under ORS 802.220(5), DMV is not authorized to provide you with a copy of the report that you file. If submitting by:

- Fax, many fax machines provide the option to generate a fax confirmation report. Save that report.
- DMV Field Office, request and save that receipt.

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 CRASH 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 crash 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 CRASH 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. 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 CRASH AND INSURANCE REPORT

COMPLETE BOTH SIDES

Complete this form if the traffic crash occurred on a highway or premise open to the public and meets at least one of the reporting requirements outlined in Section 3. Failure to report when required may result in DMV issuing Notice of Suspension. Call 503-945-5098 for assistance in completing the report.

SECTION 1	CRASH DATE (MM/DD/YY)	DAY OF WEEK C M T W T H F S S C S O S N	TIME OF DAY A M P M	COUNTY	DMV USE ONLY			ALIR <input type="checkbox"/>	INS CO <input type="checkbox"/>
	ROAD ON WHICH CRASH OCCURRED (Name of street, road or route)		MILE POST	TYPE OF CRASH - The crash involved one or more of the following: (Mark all that apply)					
	NAME OF NEAREST INTERSECTING ROAD <input type="checkbox"/> WITHIN _____ FEET C N O S C E C W <input type="checkbox"/> NEAR _____ MILES C N O S C E C W		NAME OF NEAREST CITY / TOWN <input type="checkbox"/> WITHIN _____ FEET C N O S C E C W <input type="checkbox"/> NEAR _____ MILES C N O S C E C W		<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"/> Fatality	<input type="checkbox"/> Motor Home / RV	<input type="checkbox"/> Animal	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Motorized Scooter	<input type="checkbox"/> Fixed object / property
				<input type="checkbox"/> Pedestrian	<input type="checkbox"/> Personal (assisted) mobility device	<input type="checkbox"/> Other _____			

Complete ALL fields. Failure to provide complete information may result in DMV issuing Notice of Suspension.

SECTION 2 (YOUR INFORMATION)	DRIVER'S LAST NAME	FIRST NAME	MIDDLE NAME	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	GENDER C M F O X
	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 <input type="checkbox"/> SAME <input type="checkbox"/> RENTAL?			CITY	STATE	ZIP CODE	
	INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS			CITY	STATE	ZIP CODE	
POLICY NUMBER		VEHICLE IDENTIFICATION NUMBER		STATE	VEHICLE PLATE NUMBER	YEAR	MAKE & MODEL

SECTION 3	Check all statements that apply:	<input type="checkbox"/> Damage to your vehicle was more than \$2500.
		<input type="checkbox"/> Damage to property other than a vehicle involved in the crash is over \$2500.
		<input type="checkbox"/> Your vehicle was towed from the scene as a result of damages.
		<input type="checkbox"/> You or passengers in your vehicle were injured.
		<input type="checkbox"/> Your vehicle was parked.
		<input type="checkbox"/> The crash occurred while you were driving your employer's vehicle.
		<input type="checkbox"/> You were driving on your job and being paid for the principal purpose of driving.
		<input type="checkbox"/> You were being paid to drive and/or deliver persons or property.
		<input type="checkbox"/> You were operating a government owned vehicle marked for transporting mail in accordance with government rules.
		<input type="checkbox"/> You were operating an authorized emergency vehicle.
	<input type="checkbox"/> The crash occurred in a work or maintenance zone. ORS 811.230	
	<input type="checkbox"/> A police officer came to the scene.	
	Name of police department: _____ <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State Police	
	<input type="checkbox"/> You were operating a commercial motor vehicle requiring you to have a commercial driver license.	
	<input type="checkbox"/> You were transporting hazardous material.	
	<input type="checkbox"/> A citation was issued to you. The citation was: _____	

SECTION 4 (OTHER VEHICLE #2)	DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	GENDER C M F O X
	DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
	VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	
	INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS				
	POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	STATE	VEHICLE PLATE NUMBER	YEAR

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

SECTION 5	DESCRIBE WHAT HAPPENED: (IF MORE SPACE IS NEEDED, SUBMIT ADDITIONAL PAGE)

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT X	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE # ()	DATE SIGNED
IF NOT DRIVER'S SIGNATURE, STATE RELATIONSHIP	REASON DRIVER IS UNABLE TO SIGN REPORT	PHONE NUMBER OF DRIVER ()	

YOU INTENDED TO... <input type="checkbox"/> Go straight ahead <input type="checkbox"/> Make right turn <input type="checkbox"/> Make left turn <input type="checkbox"/> Make "U" turn <input type="checkbox"/> Back up <input type="checkbox"/> Enter driveway (also mark left or right turn) <input type="checkbox"/> Remain stopped in traffic <input type="checkbox"/> Enter parked position <input type="checkbox"/> Slow or Stop <input type="checkbox"/> Leave driveway (also mark left or right turn) <input type="checkbox"/> Start in traffic lane <input type="checkbox"/> Leave parked position <input type="checkbox"/> Remain parked <input type="checkbox"/> Overtake and pass	YOUR VEHICLE <input type="checkbox"/> Passenger car, pickup, van <input type="checkbox"/> Military vehicle <input type="checkbox"/> Taxicab <input type="checkbox"/> Emergency vehicle <input type="checkbox"/> Any of the above and trailer <input type="checkbox"/> Private or public agency transit vehicle <input type="checkbox"/> Bus <input type="checkbox"/> School bus <input type="checkbox"/> Other publicly-owned veh. <input type="checkbox"/> Motorcycle <input type="checkbox"/> Motor Home / RV <input type="checkbox"/> Motor-scooter/bike <input type="checkbox"/> Personal (assisted) mobility device <input type="checkbox"/> Truck tractor & semi trailer <input type="checkbox"/> Truck/truck tractor <input type="checkbox"/> Other truck combination <input type="checkbox"/> Farm tractor/farm equip.	WEATHER CONDITIONS <input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Fog <input type="checkbox"/> Other <hr/> ROAD SURFACE <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Snowy <input type="checkbox"/> Icy <input type="checkbox"/> Other <hr/> LIGHT CONDITIONS <input type="checkbox"/> Daylight <input type="checkbox"/> Dawn or dusk <input type="checkbox"/> Darkness (lighted) <input type="checkbox"/> Darkness (unlighted) <input type="checkbox"/> Other	YOUR RESIDENCE <input type="checkbox"/> Local resident <small>(within 25 miles of crash site)</small> <input type="checkbox"/> Residing elsewhere in state <input type="checkbox"/> Non-resident of this state: <input type="checkbox"/> College student <input type="checkbox"/> Military <input type="checkbox"/> Temporary job <hr/> YOU WERE HEADED <input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West On: _____ <small>(name of street, road or route)</small> <hr/> OTHER DRIVER WAS HEADED <input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West On: _____ <small>(name of street, road or route)</small>
---	--	---	---

WITNESS INFORMATION:

If this crash 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.)

OCCUPANT 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 but NOT used 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 Fatal 2 Suspected Serious: severe laceration, broken or distorted limb, crush injury, significant burns, unconsciousness, paralysis 3 Suspected Minor: lump, abrasions, bruises, minor lacerations 4 Possible 5 No apparent
--	---

SEAT POSITION	OCCUPANTS' NAMES (your vehicle)	A		B		C		D
		GENDER	AGE	SFTY EQP	AIR BAG	INJURY		
DRIVER								
FRONT CENTER								
FRONT RIGHT								
MIDDLE* LEFT								
MIDDLE* CENTER								
MIDDLE* RIGHT								
REAR LEFT								
REAR CENTER								
REAR RIGHT								

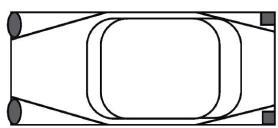
* Use only for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

Gender and age of pedestrian / bicyclist:
 M F X Age: _____

Extent of pedestrian / bicyclist injury:
 Fatal Complaint of Pain
 Suspected Serious No apparent injury (or none noted)
 Visible 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

Diagram

Number each vehicle: 1 2

Show path by: →

Show pedestrian/bicyclist by: ○

Show railroad tracks by: |||

Show fixed object by: X

--- (name of street, road or route) ↑

--- (name of street, road or route) ↑

← (name of street, road or route)



SUPPLEMENTAL REPORT OREGON TRAFFIC CRASH

**Supplemental for more than two drivers involved in the crash.
Attach this form to your OREGON TRAFFIC CRASH AND INSURANCE REPORT.**

CRASH DATE (MM/DD/YY) / /	DAY OF WEEK M T W T H F S S N	TIME OF DAY AM PM	COUNTY	DO NOT WRITE IN THIS SPACE
ROAD ON WHICH CRASH OCCURRED (Name of street, road or route)			MILE POST	

VEHICLE #3	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 GENDER OM OF CX
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #4	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 GENDER OM OF CX
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #5	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 GENDER OM OF CX
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #6	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 GENDER OM OF CX
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #7	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 GENDER OM OF CX
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

(For CMV Drivers Only)

INSTRUCTIONS: IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN AND A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE MOTOR CARRIER CRASH REPORT AND SUBMIT TO THE ADDRESS SHOWN ABOVE. IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER CRASH REPORT, PLEASE CALL (503) 986-3507. www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/

QUALIFYING VEHICLE		CRITERIA	
<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.)		<input type="checkbox"/> ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE CRASH) <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
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	LENGTH OF EMPLOYMENT YEARS MONTHS EXPIRATION DATE OF MEDICAL CERTIFICATE

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




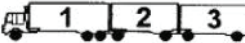
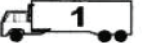




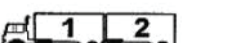

AT TIME OF THE CRASH, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD. _____	TOTAL HOURS ON DUTY DURING THE PREVIOUS (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)	7 CONSECUTIVE DAYS _____ 8 CONSECUTIVE DAYS _____
DOES YOUR DRIVER HAVE A MEDICAL WAIVER <input type="checkbox"/> YES <input type="checkbox"/> 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

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	LICENSE PLATE # & STATE - TRUCK/TRACTOR/BUS	TOTAL NO. OF AXLES INCLUDING TRAILERS

TRACTOR 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  Auto/Tractor	<input type="checkbox"/> 11  Auto/Pickup		
<input type="checkbox"/> 4  Doubles (any)	<input type="checkbox"/> 8  Saddlemount			

TRAILER TYPE (CHECK ONE)

- VAN FLATBED TANKER CONTAINER POLE/LOG DUMP BELLY-DUMP CAR CARRIER LIVESTOCK
 MOBILE HOME TOWER PASSENGER DROP-BOX GARBAGE BULK-HOPPER MIXER SADDLEMOUNT
 WRECKER FIXED LOAD HEAVY HAUL UTILITY

COMMODITY INFORMATION

COMMODITY BEING TRANSPORTED AT TIME OF CRASH

 WAS A HAZARDOUS COMMODITY BEING HAULED
 YES NO

 WAS HAZARDOUS MATERIAL RELEASED FROM
 THE VEHICLE CARGO (NOT A FUEL RELEASE) YES NO

HAZARD CLASS

CRASH INFORMATION

LOCATION OF CRASH (NEAREST CITY OR TOWN)

HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD

DIRECTION OF YOUR VEHICLE (CHECK)

 N S E W

DATE OF CRASH

TIME

 AM
 PM

DAY OF THE WEEK (CHECK ONE)

 MON TUES WED THU FRI SAT SUN
CONDITIONS AT TIME OF CRASH
 WEATHER (CHECK ONE) 1. CLEAR 2. RAIN 3. SNOW 4. CLOUDY 5. SLEET 6. FOG 7. OTHER _____

 ROAD SURFACE (CHECK ONE) 1. DRY 2. WET 3. SNOWY 4. ICY 5. OTHER _____

 LIGHT CONDITION (CHECK 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 1 2 3	ACTION	VEHICLES 1 2 3	ACTION	VEHICLES 1 2 3	ACTION
	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
 YES NO

 WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE
 YES NO
DESCRIPTION OF CRASH (BY CARRIER OR DRIVER)

NAME AND TITLE OF PERSON SIGNING REPORT

TELEPHONE NUMBER(S)

SIGNATURE I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE

DATE

X