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 $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 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.
- 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 agent) 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.

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. Call (503) 986-3507 for questions regarding the *Motor Carrier Crash Report.*

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. 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

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.**

MAIL — Mail the form to Accident Reporting Unit, DMV, 1905 Lana Ave NE, Salem OR 97314 or FAX to (503) 945- 5267, or deliver it to any DMV office.

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. 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

DMV

COMPLETE BOTH SIDES

Print Form | Reset Form

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 $2500 in damage to your vehicle; 2) More than $2500 in damage to any one person's property other than a vehicle; 3) Any vehicle has more than $2500 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.

SECTION 1

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY

DO NOT WRITE IN THIS SPACE Accident Number _____

ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route) | MILE POST

☐ WITHIN _____ FEET ☐N ☐S ☐E ☐W NAME OF NEAREST INTERSECTING ROAD

☐ NEAR _____ MILES ☐N ☐S ☐E ☐W

☐ WITHIN _____ FEET ☐N ☐S ☐E ☐W NAME OF NEAREST CITY / TOWN

☐ NEAR _____ MILES ☐N ☐S ☐E ☐W

TYPE OF ACCIDENT - The accident involved one or more of the following: **(Mark all that apply)**

☐ Two vehicles	☐ ATV / Snowmobile	☐ Parked vehicle
☐ More than two vehicles	☐ Motorcycle	☐ Overturned vehicle
☐ Fatality	☐ Motorized Scooter	☐ Animal
☐ Bicycle	☐ Personal (assisted) mobility device	☐ Fixed object / property
☐ Pedestrian	☐ Train	☐ Other _____

SECTION 2 (YOUR VEHICLE # 1)

Complete ALL of this section. If you fail to do so, your driving privileges may be suspended. You **MUST** list the insurance company (not agent) 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 (CIRCLE) ☐M ☐F ☐X

DRIVER'S RESIDENCE ADDRESS	CITY	STATE	ZIP CODE	☐ CHECK BOX IF ADDRESS CHANGE

MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS ☐ SAME	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME **(NOT AGENT)** AND ADDRESS	CITY	STATE	ZIP CODE

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

SECTION 3

Check all statements that apply:

- ☐ **Damage to your vehicle was more than $2500.**
- ☐ **Damage to any one person's property (other than vehicle) was more than $2500.**
- ☐ **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.
- ☐ The accident occurred in a work or maintenance zone. ORS 811.230
- ☐ A police officer came to the scene.
  - Name of police department: _____ ☐ City ☐ County ☐ State Police
- ☐ 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	SEX (CIRCLE) ☐M ☐F ☐X

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS ☐ SAME	CITY	STATE	ZIP CODE

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: (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 (SEE SECTION 5)	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE #	DATE SIGNED
X		( )	

IF **NOT** DRIVER'S SIGNATURE, STATE RELATIONSHIP	REASON DRIVER IS UNABLE TO SIGN REPORT	PHONE NUMBER OF DRIVER
		( )

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.)

Sex and age of pedestrian / bicyclist:
☐ M ☐ F ☐ X 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)

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**

SEX CODE

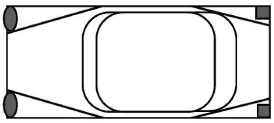
WRITE M, F or X in column **A**

SEAT POSITION	PASSENGER'S NAMES (your vehicle)	A SEX	B AGE	C SFTY EQP	C AIR BAG	D 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.)

Vehicle Damage

FRONT

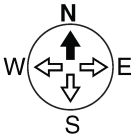


USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)

- ☐ Vehicle towed
- ☐ Rollover
- ☐ Under car
- ☐ Totaled
- ☐ Unknown

Your Vehicle (No. 1) damage: $ _____ .

Diagram



Number each vehicle: 1 2
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
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)		MILE POST	

DO NOT WRITE IN THIS SPACE

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	SEX (CIRCLE) M F X
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
☐ SAME				

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	SEX (CIRCLE) M F X
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
☐ SAME				

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	SEX (CIRCLE) M F X
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
☐ SAME				

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	SEX (CIRCLE) M F X
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
☐ SAME				

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	SEX (CIRCLE) M F X
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE	
☐ SAME				

SUPPLEMENTAL REPORT – USE IF MORE THAN TWO VEHICLES

ACCIDENT REPORTING UNIT
OREGON DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE. NE
SALEM OR 97314
FAX: (503) 945-5267

MOTOR CARRIER CRASH REPORT

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.**

QUALIFYING VEHICLE

- ☐ COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF CRASH EVEN IF GVWR IS SET UNDER 10,000 LBS)
- ☐ HAZARDOUS MATERIAL PLACARD
- ☐ COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS)
- ☐ FARM TRUCK INTERSTATE (OVER 10,000 LBS.)
- ☐ FARM TRUCK FOR-HIRE (4 OR MORE AXLES)
- ☐ FARM TRUCK TOWING TRIPLE TRAILERS
- ☐ FARM TRUCK (OVER 80,000 LBS.)

CRITERIA

- ☐ ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE ACCIDENT)
- ☐ ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE
- ☐ 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 ☐ A ☐ B ☐ C ☐ D ☐ 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 ☐ YES ☐ NO	TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)	

DRIVER INJURY INFORMATION

YOUR DRIVER KILLED	YOUR DRIVER INJURED	RELIEF DRIVER KILLED	RELIEF DRIVER INJURED	TOTAL NUMBER OF PASSENGERS
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	_____KILLED _____ INJURED

OTHER DRIVER INJURY INFORMATION

TOTAL NUMBER OF OTHER DRIVERS	TOTAL NUMBER OF OTHER PASSENGERS	TOTAL NUMBER OF PEDESTRIANS	TOTAL NUMBER OF BICYCLISTS
_____KILLED _____ INJURED	_____KILLED _____ INJURED	_____KILLED _____ INJURED	_____KILLED _____ INJURED

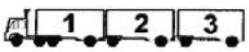
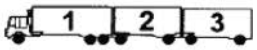
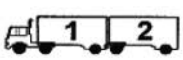
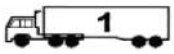
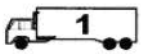
OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

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

MOTOR CARRIER VEHICLE INFORMATION

YEAR	MAKE	UNIT NUMBER	TRUCK/TRACTOR/BUS LICENSE PLATE NO. & STATE	TOTAL NO. OF AXLES INCLUDING TRAILERS

VEHICLE TYPE (SELECT APPROPRIATE TYPE)

- ☐ 1  Triples (tractor with 3 trailers
- ☐ 2  Triples (truck with 2 trailers)
- ☐ 3 Straight truck-full trailer
- ☐ 4  Doubles (any)
- ☐ 5  Standard Tractor/Semi Trailer
- ☐ 6  Straight Truck
- ☐ 7
- ☐ 8 Saddlemount
- ☐ 9 Heavy Haul
- ☐ 10 Bus/Van (8 or more passenger capacity)
- ☐ 11 Auto/Pickup

☐ **COMPLETE REVERSE SIDE**

SUPPLEMENTAL – MOTOR CARRIER CRASH REPORT

CARGO BODY TYPE (CIRCLE ONE)

VAN FLATBED TANKER CONTAINER POLE DUMP BELLY-DUMP CAR CARRIER LIVESTOCK
MOBILE HOME TOTER 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	WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO(NOT A FUEL RELEASE)	HAZARD CLASS
YES NO	YES NO	

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	DAY OF THE WEEK (CIRCLE ONE)
	AM PM	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 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	WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE
YES NO	YES NO

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 X	DATE