# OREGON TRAFFIC COLLISION AND INSURANCE REPORT

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

Oregon law requires **the driver of a motor vehicle involved in a collision that happened in Oregon** to submit a report to DMV within 72 hours when **any of these** are true:

- **Injury or death resulted from the collision**
- **Damage to anyone's property other than a vehicle involved in the collision is over $2,500.**
- **Damage to your vehicle is over $2,500**
- **Damage to any vehicle is over $2,500 AND any vehicle is towed from the scene.**

If you are not able to file a report within 72 hours of the collision, submit one as soon as possible. If you do not file a report when required, Oregon law requires DMV to suspend your driving privileges. **You still need to file a report with DMV even if law enforcement files a police report. When required to report, you must file a report even if you are licensed in another state or you are not an Oregon resident.** DMV does not determine fault in a collision, but we are required by law to post the collision to the driving record of drivers required to report. **If you have questions, please call the 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 collision, 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 Vehicle" Section.
- DMV will verify the insurance information you submit. DMV may suspend your driving privileges if you do not complete the insurance section.

## SECTION 1

**DATE, LOCATION AND TIME** — Clearly identify the date, location and time of the collision. This information is critical for processing your report. If you don't know the county, contact any local law enforcement agency for help.

## SECTION 2

Your vehicle is Vehicle #1. Complete ALL fields. **Write your insurance company name (not agent), policy number, and vehicle identification number (VIN).** DMV may suspend your driving privileges if you fail to give complete insurance and vehicle information.

## SECTION 3

Check all statements that apply. Principal purpose of driving and being paid to drive does not include driving to 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 Collision Report*, MUST** be filed within 30 days of a commercial motor vehicle collision 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 Collision and Insurance Report* (Form 735-32) to DMV.

*You may file the Motor Carrier Collision Report online at: www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/*

## SECTION 4

**OTHER VEHICLE (# 2)** — Completion of this information will help DMV match all drivers' collision reports more efficiently. If additional vehicles were involved in the collision, 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

**HOW TO SUBMIT A REPORT TO DMV:**

- Online at DMV2U.Oregon.gov (scan QR code on this page)
- Fax to 503-945-5267
- Mail to DMV Crash Reporting Unit 1905 Lana Ave NE, Salem, Oregon 97314
- Deliver to a DMV field 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 CANNOT 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 COLLISION 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 collision 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 COLLISION 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 Form 735-229.

**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 COLLISION AND INSURANCE REPORT

COMPLETE BOTH SIDES

Reset Form

Complete this form if the traffic collision was caused by the motion of a vehicle or its load and meets at least one of the reporting requirements on the front page of this form. DMV may suspend your driving privileges if you fail to report when required. Call 503-945-5098 if you have questions or need help with completing the report.

## SECTION 1

| COLLISION DATE (MM/DD/YY) | DAY OF WEEK | TIME OF DAY | COUNTY | DMV USE ONLY |
|---|---|---|---|---|
| / / | ○M ○T ○W ○TH ○F ○S ○SN | : ○AM ○PM | | ALIR ☐ INS CO ☐ |

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

NAME OF NEAREST INTERSECTING ROAD — ☐ WITHIN ____ FEET ○N ○S ○E ○W ☐ NEAR ____ MILES ○N ○S ○E ○W

NAME OF NEAREST CITY / TOWN — ☐ WITHIN ____ FEET ○N ○S ○E ○W ☐ NEAR ____ MILES ○N ○S ○E ○W

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

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

## SECTION 2 (YOUR INFORMATION)

**Complete ALL fields. DMV may suspend your driving privileges if you fail to give complete information.**

| DRIVER'S LAST NAME | FIRST NAME | MIDDLE NAME | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH (MM/DD/YYYY) | GENDER |
|---|---|---|---|---|---|---|
| | | | | | | ○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 | CITY | STATE | ZIP CODE
☐ SAME
☐ RENTAL?

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

| POLICY NUMBER | VEHICLE IDENTIFICATION NUMBER (VIN) | STATE | VEHICLE PLATE NUMBER | YEAR | MAKE & MODEL |
|---|---|---|---|---|---|
| | | | | | |

## SECTION 3

**Check all statements that apply:**

- ☐ **Damage to your vehicle was more than $2500.**
- ☐ **Damage to property other than a vehicle involved in the collision is over $2500.**
- ☐ **Your vehicle was towed from the scene as a result of damages.**
- ☐ **You or passengers in your vehicle were injured (no matter how minor).**
- ☐ Your vehicle was parked.
- ☐ The collision 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.
- ☐ The collision 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
- ☐ You were operating a commercial motor vehicle requiring you to have a commercial driver license.
  - ☐ You were transporting hazardous materials.
- ☐ A citation was issued to you. The citation was for: _____

## SECTION 4 (OTHER VEHICLE # 2)

| DRIVER'S NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER |
|---|---|---|---|---|
| | | | | ○M ○F ○X |

DRIVER'S ADDRESS | CITY | STATE | ZIP CODE

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

INSURANCE COMPANY NAME **(NOT AGENT)** AND ADDRESS

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

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE COLLISION, 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 | 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 | CONTACT PHONE NUMBER |
|---|---|---|
| | | ( ) - |

DATE OF BIRTH:

## YOU INTENDED TO...

- ☐ Go Straight Ahead
- ☐ Overtake and Pass
- ☐ Merge
- ☐ Change Lanes
- ☐ Make Right Turn
- ☐ Make Left Turn
- ☐ Make "U" Turn
- ☐ Back Up
- ☐ Enter Driveway with a Left Turn
- ☐ Enter Driveway with a Right Turn
- ☐ Leave Driveway with a Left Turn
- ☐ Leave Driveway with a Right Turn
- ☐ Enter Parked Position
- ☐ Leave a Parked Position
- ☐ Remain Parked
- ☐ Slow or Stop
- ☐ Start in Traffic Lane
- ☐ Remain Stopped in Traffic

## YOUR VEHICLE TYPE

- ☐ Passenger car, pickup, SUV, van)
- ☐ Motorcycle (2 or 3 wheels)
- ☐ Moped, Motorized scooter (seated), or motorized bicycle
- ☐ Motorized scooter (standing)
- ☐ Motorhome
- ☐ Truck tractor with trailer
- ☐ Truck with non-detachable bed
- ☐ Truck tractor with no trailer
- ☐ Bus
- ☐ School bus
- ☐ Farm tractor or self-propelled farm equip
- ☐ ATV/Snowmobile
- ☐ Other (not listed above)

## YOUR VEHICLE'S SPECIAL USE

- ☐ No special use
- ☐ Emergency vehicle
- ☐ Military
- ☐ Taxicab
- ☐ Private or public agency transit veh.
- ☐ Other publicly owned vehicle

## WEATHER CONDITIONS

- ☐ Clear
- ☐ Cloudy
- ☐ Rain
- ☐ Sleet, Freezing Rain, Hail
- ☐ Fog
- ☐ Snow
- ☐ Dust
- ☐ Smoke
- ☐ Ash

## ROAD SURFACE

- ☐ Dry
- ☐ Wet
- ☐ Snow
- ☐ Ice

## LIGHT CONDITIONS

- ☐ Daylight
- ☐ Darkness, with street lights
- ☐ Darkness, no street lights
- ☐ Dawn (Twilight)
- ☐ Dusk (Twilight)

## YOUR RESIDENCE

- ☐ Oregon resident, collision location was within 25 miles of home
- ☐ Oregon resident, collision location was more than 25 miles from home
- ☐ Oregon resident, collision location was an unknown number of miles from home
- ☐ Non-resident of Oregon

## YOU WERE HEADED

☐ North ☐ East ☐ NE ☐ SE
☐ South ☐ West ☐ NW ☐ SW

On: _____
(name of street, road or route)

## OTHER DRIVER WAS HEADED

☐ North ☐ East ☐ NE ☐ SE
☐ South ☐ West ☐ NW ☐ SW

On: _____
(name of street, road or route)

**WITNESS INFORMATION:**

_____

_____

## If this collision involved a pedestrian or bicyclist, complete the following:

☐ **PEDESTRIAN NAME** ☐ **BICYCLIST NAME**

Pedestrian or bicyclist was going:
☐ N ☐ S ☐ E ☐ W ☐ NE ☐ NW ☐ SE ☐ SW

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

**Starting from:**

**To:**

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

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

**Extent of pedestrian / bicyclist injury:**
☐ Fatal ☐ Possible
☐ Suspected Serious ☐ No apparent injury (or none noted)
☐ Suspected Minor

**Pedestrian / bicyclist action:** (mark one)
- ☐ Crossing at intersection or crosswalk
- ☐ Crossing **not** at intersection or crosswalk
- ☐ Walking or riding in roadway with traffic
- ☐ Walking or riding in roadway **against** traffic
- ☐ Standing or lying down in roadway
- ☐ Pushing or working on vehicles in roadway
- ☐ Other working in roadway
- ☐ Playing in road
- ☐ Hitchhiking
- ☐ Not in roadway
- ☐ Using personal mobility device (e.g., wheelchair, skateboard, etc.)
- ☐ Other specify) _____

## OCCUPANT INJURY AND SAFETY EQUIPMENT IN YOUR VEHICLE

### 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: momentary loss of consciousness, claim of injury, limping, complaint of pain or nausea
**5** No apparent

### GENDER CODE
WRITE M, F or X in column **A**

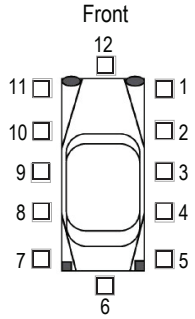
| SEAT POSITION | OCCUPANTS' NAMES (your vehicle) | A GENDER | B AGE | C SFTY EQP | C AIR BAG | D INJURY |
|---|---|---|---|---|---|---|
| **DRIVER** | | | | | | |
| FRONT CENTER | | | | | | |
| FRONT RIGHT | | | | | | |
| MIDDLE* LEFT | | | | | | |
| MIDDLE* CENTER | | | | | | |
| MIDDLE* RIGHT | |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

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

## Vehicle Damage & Impact Points

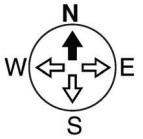
Check the appropriate box to indicate the First Contact Point.

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




Write the number(s) corresponding to any additional impacts that occurred after the first contact point: _____

## 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 COLLISION

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

| COLLISION DATE (MM/DD/YY) | DAY OF WEEK | TIME OF DAY | COUNTY |
|---|---|---|---|
| / / | M T W TH F S SN | AM / PM | |

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

**DO NOT WRITE IN THIS SPACE**

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**VEHICLE #3**

INSURANCE COMPANY NAME (NOT AGENT) | POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE PLATE NUMBER | STATE | YEAR | MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER M F X

DRIVER'S ADDRESS | CITY | STATE | ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS | CITY | STATE | ZIP CODE

☐ SAME

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**VEHICLE #4**

INSURANCE COMPANY NAME (NOT AGENT) | POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE PLATE NUMBER | STATE | YEAR | MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER M F X

DRIVER'S ADDRESS | CITY | STATE | ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS | CITY | STATE | ZIP CODE

☐ SAME

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**VEHICLE #5**

INSURANCE COMPANY NAME (NOT AGENT) | POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE PLATE NUMBER | STATE | YEAR | MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER M F X

DRIVER'S ADDRESS | CITY | STATE | ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS | CITY | STATE | ZIP CODE

☐ SAME

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**VEHICLE #6**

INSURANCE COMPANY NAME (NOT AGENT) | POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE PLATE NUMBER | STATE | YEAR | MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER M F X

DRIVER'S ADDRESS | CITY | STATE | ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS | CITY | STATE | ZIP CODE

☐ SAME

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**VEHICLE #7**

INSURANCE COMPANY NAME (NOT AGENT) | POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE PLATE NUMBER | STATE | YEAR | MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER | STATE | DATE OF BIRTH | GENDER 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**

CRASH ANALYSIS & REPORTING UNIT
OREGON DEPARTMENT OF TRANSPORTATION
POLICY, DATA & ANALYSIS DIVISION
355 CAPITOL ST NE, MS 41
SALEM OR 97301
EMAIL ODOTCARCMVCrashSupport@odot.oregon.gov
TELEPHONE 503-986-3507
FAX 503-986-3592

# MOTOR CARRIER COLLISION 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 COLLISION REPORT. SUBMIT TO THE ADDRESS SHOWN ABOVE, OR USE THE LINK BELOW TO SUBMIT ONLINE.
**IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER COLLISION REPORT, PLEASE CALL (503) 986-3507.**
www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/

## QUALIFYING VEHICLE

- ☐ COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF COLLISION 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 COLLISION)
- ☐ 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 COLLISION.

| AT TIME OF THE COLLISION, 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 |

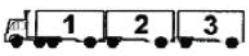
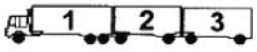
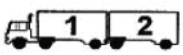
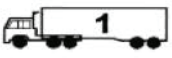
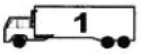
## OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

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

## MOTOR CARRIER VEHICLE INFORMATION

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

## TRACTOR 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  Tractor Only
- ☐ 8  Saddlemount
- ☐ 9  Heavy Haul
- ☐ 10  Bus/Van (8 or more passenger capacity)
- ☐ 11  Auto/Pickup



☐ **COMPLETE REVERSE SIDE**

**SUPPLEMENTAL – MOTOR CARRIER COLLISION REPORT**

**TRAILER TYPE (CHECK ONE)**

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

## COMMODITY INFORMATION

| COMMODITY BEING TRANSPORTED AT TIME OF COLLISION | | |
|---|---|---|
| WAS A HAZARDOUS COMMODITY BEING HAULED ☐ YES ☐ NO | WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO (NOT A FUEL RELEASE) ☐ YES ☐ NO | HAZARD CLASS |

## COLLISION INFORMATION

| LOCATION OF COLLISION (NEAREST CITY OR TOWN) | HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD | DIRECTION OF YOUR VEHICLE (CHECK) ☐ N ☐ S ☐ E ☐ W |
|---|---|---|
| DATE OF COLLISION | TIME ☐ AM ☐ PM | DAY OF THE WEEK (CHECK ONE) ☐ MON ☐ TUES ☐ WED ☐ THU ☐ FRI ☐ SAT ☐ SUN |

## CONDITIONS AT TIME OF COLLISION

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. SNOW ☐ 4. ICE ☐ 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 COLLISION (BY CARRIER OR DRIVER)

| NAME AND TITLE OF PERSON SIGNING REPORT | TELEPHONE NUMBER(S) |
|---|---|
| SIGNATURE I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE<br>X | DATE |