

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 Motor Vehicle Safety, 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 _____ Day of _____ Accident _____ 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 OCCURRED 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 _____ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Driver License _____ Is this vehicle covered by automobile liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES TO EITHER SHOW INSURANCE COMPANY Name _____ State Number _____ If vehicle not covered, did driver have liability policy applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No Show Policy Number Here Address _____ Show name of insurance company not name of insurance agency.		
Space for any third vehicle on reverse side. Total vehicles involved	OTHER VEHICLE NUMBER 2 Year _____ Make _____ Type (sedan, truck, taxi, bus, etc.) _____ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Driver License _____ 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 _____ State _____ Number _____		
DAMAGE TO PROPERTY OTHER THAN VEHICLE _____		Approximate cost to repair \$ _____	
NAME OBJECT AND STATE NATURE OF DAMAGE			
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 _____ Driver's License Number _____ Driver's Birth Date _____ Age _____ Sex _____
Carpenter, Sales Clerk, Etc. State _____ Mo. Da Yr

Owner _____
Full Name _____ Street _____ City and State _____ Own er'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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Name _____ Address _____ Driver In Vehicle
 Passenger No. _____
 Pedestrian
 Specify other _____

Age _____ Sex _____ Race _____ Injured taken to _____
Nature and extent of injuries _____ Attending Doctor _____

Did injured die? _____

Name _____ Address _____ Driver In Vehicle
 Passenger No. _____
 Pedestrian
 Specify other _____

Age _____ Sex _____ Race _____ Injured taken to _____
Nature and extent of injuires _____ Attending Doctor _____

Did injured die? _____

Total Injured

Light Conditions Daylight Dawn or Dusk Darkness

What Pedestrian Was Doing
Pedestrian was going N S E W Across or into _____ From _____ To _____
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.