

VEHICLE INCIDENT REPORT FORM



Incident TYPE

Incident type is (check one):	<input type="checkbox"/> Two (or more) vehicles	<input type="checkbox"/> Vehicle and pedestrian(s)	<input type="checkbox"/> Vehicle only (e.g. hit a tree)
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WHEN did the incident happen?

Date	Day of Week	Time	<input type="checkbox"/> AM	<input type="checkbox"/> PM
Weather Conditions		Road Conditions		

What PEOPLE were involved?

VEHICLE 1			
Driver Name			
Driver Phone			
Driver Insurance Policy (Carrier and Policy Number)			
Was driver's seat belt on?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was driver (check all that apply):			
<input type="checkbox"/> Sleep deprived?	<input type="checkbox"/> On OTC medication?		
<input type="checkbox"/> On overtime hours?	<input type="checkbox"/> On prescription meds?		
Cited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If Yes, cited for:</i>
<i>Describe injuries. Taken to hospital or treated at scene?</i>			

VEHICLE 2			
Driver Name			
Driver Phone			
Driver Insurance Policy (Carrier and Policy Number)			
Was driver's seat belt on?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was driver (check all that apply):			
<input type="checkbox"/> Sleep deprived?	<input type="checkbox"/> On OTC medication?		
<input type="checkbox"/> On overtime hours?	<input type="checkbox"/> On prescription meds?		
Cited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If Yes, cited for:</i>
<i>Describe injuries. Taken to hospital or treated at scene?</i>			

PASSENGERS • VEHICLE 1	
Passenger 1 Name	Passenger 2 Name
Passenger 1 Phone	Passenger 2 Phone
<i>Describe injuries. Taken to hospital or treated at scene?</i>	<i>Describe injuries. Taken to hospital or treated at scene?</i>

WITNESSES AT SCENE (Who were **NOT** involved in the incident)

Witness 1 Name
Witness 1 Phone

Witness 2 Name
Witness 2 Phone

LAW OFFICER AT SCENE

Officer Name
Officer Phone
Officer Badge No.

Officer's Jurisdiction
Police Report Number

What **VEHICLES** were involved?

VEHICLE 1			
Make/Model/Year			
Commercial vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
License Plate (State and Number)			
Towed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Towing Company			
Is DRIVER the OWNER of vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

VEHICLE 2			
Make/Model/Year			
Commercial vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
License Plate (State and Number)			
Towed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Towing Company			
Is DRIVER the OWNER of vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

DOCUMENTATION or MEDIA

VIDEO or PHOTOS taken?
By whom?
Video or photo taker's contact info

WHERE did the incident happen?

STREET Address OR INTERSECTION

SKETCH the incident scene as if you were a bird flying over it. Label all streets. Indicate lanes and use arrows to indicate the direction vehicles were traveling.



What happened?

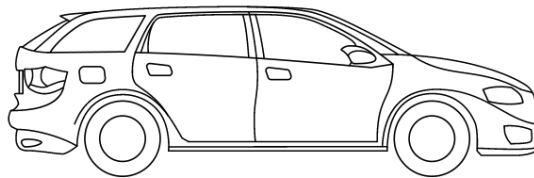
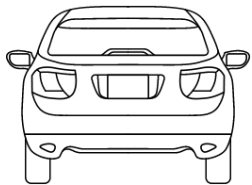
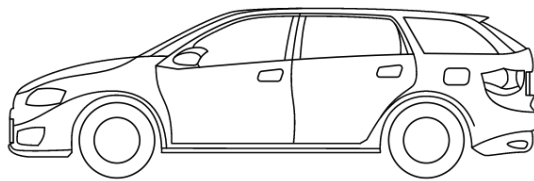
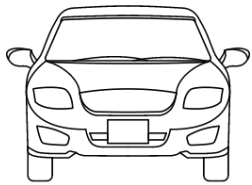
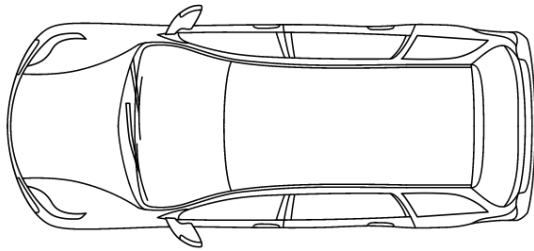
In your description, **do not use pronouns** (he, she, it) to refer to people or vehicles. Use their names. Be sure to describe any vehicle malfunctions or conditions that contributed to the incident.

DESCRIBE the incident and the **sequence** in which things happened.

What was the damage?

VEHICLE 1

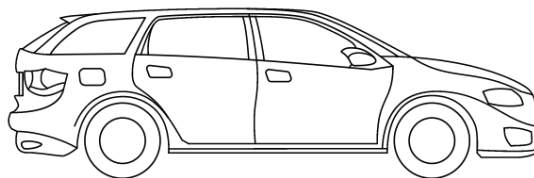
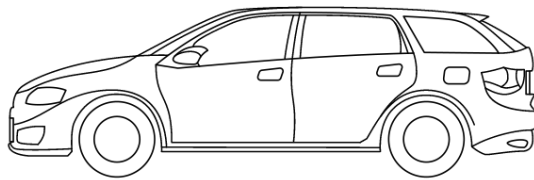
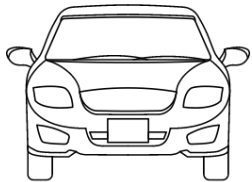
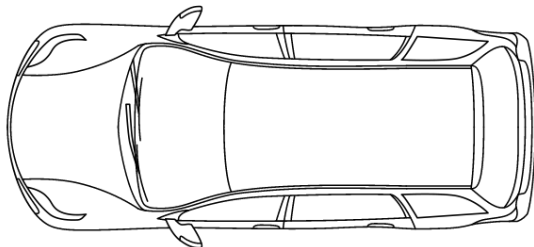
Mark the diagram to show areas of damage.



Cargo damage? If yes, list and describe.

VEHICLE 2

Mark the diagram to show areas of damage.



Cargo damage? If yes, list and describe.

Report submitted by:	Name	Phone
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