

POST-ACCIDENT REPORT FORM

Keep in your glove box!

WHAT TO DO

If you've been in an accident, *stay calm*. Make sure you're not injured. Administer first aid if necessary and call emergency services. While waiting, get as much information as you can. Take pictures of the scene and the damage.

WHAT NOT TO DO

Don't say it was your fault, even if it was.

Don't talk to the other driver if you can help it except to check on his injuries or to collect information.

YOUR INFORMATION

Name: _____

Address: _____

Phone Number: _____

Email: _____

YOUR VEHICLE INFO

Make: _____

Model: _____

Year: _____

Color: _____

VIN: _____

License Plate: _____

OTHER DRIVER'S INFORMATION

Name: _____

Address: _____

Phone Number: _____

Email: _____

OTHER DRIVER'S VEHICLE INFO

Make: _____

Model: _____

Year: _____

Color: _____

VIN: _____

License Plate: _____

ACCIDENT DETAILS

Date/Time of Accident: _____

Location of Accident/Road Name:

Accident Details: _____

Speed at Impact: _____

Wearing Seatbelts: _____

Road Surface: _____

Pedestrians: _____

CONDITION OF ROADS

Lanes Marked ___ Y ___ N

Concrete ___ Y ___ N

Blacktop ___ Y ___ N

Unmarked ___ Y ___ N

Gravel ___ Y ___ N

Other _____

No Defects ___ Y ___ N

Dry ___ Y ___ N

Wet ___ Y ___ N

Ice ___ Y ___ N

Snow ___ Y ___ N

Mud ___ Y ___ N

Loose Material ___ Y ___ N

Cracks/Holes/Potholes ___ Y ___ N

Under Construction ___ Y ___ N

Other _____

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TRAFFIC CONTROLS

Traffic light ___ Y ___ N
 Stop sign ___ Y ___ N
 Yield sign ___ Y ___ N
 Police officer ___ Y ___ N
 RR crossing/gate ___ Y ___ N
 No traffic control ___ Y ___ N

Posted speed limit ___ Y ___ N
 -----MPH

TYPE OF ACCIDENT

Collision with other vehicle ___ Y ___ N
 Collision with fixed object ___ Y ___ N
 Ran off road ___ Vehicle 1 ___ Vehicle 2
 Overturned vehicle ___ Vehicle 1 ___ Vehicle 2
 Mechanical defect ___ Vehicle 1 ___ Vehicle 2
 Fire ___ Vehicle 1 ___ Vehicle 2
 Loading or unloading ___ Vehicle 1 ___ Vehicle 2
 Occupant fell out ___ Vehicle 1 ___ Vehicle 2
 Occupant injured in vehicle ___ Vehicle 1 ___ Vehicle 2
 Other -----

PEDESTRIANS

Crossing street at intersection ___ Y ___ N
 Between intersections ___ Y ___ N
 With signal ___ Y ___ N
 Against signal ___ Y ___ N
 No signal ___ Y ___ N
 On crosswalk ___ Y ___ N
 On sidewalk ___ Y ___ N
 No sidewalk ___ Y ___ N
 With traffic ___ Y ___ N
 Against traffic ___ Y ___ N
 Other -----

WEATHER CONDITIONS (Circle all that apply)

Clear Snow Sleet Fog

Rain Daylight Sunny Dawn

Sunset Dark: road lit Dark: road unlit

Other (specify): -----

DAMAGE DESCRIPTIONS

Vehicle 1

Vehicle 2

Vehicle 3

	Vehicle 1	Vehicle 2	Vehicle 3
Point of Impact			
Front			
Rear			
Right Front			
Left Front			
Right Rear			
Left Rear			
Right Side			
Left Side			
Roof			
Front Bumper			
Back Bumper			

Other -----

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VEHICLE MOVEMENT

Vehicle 1

Vehicle 2

Vehicle 3

Straight			
Turning Right			
Turning Left			
Slowing or Stopping			
Stopped in Traffic			
Starting in Traffic			
Starting from Curb/Shoulder			
Parked			
Backing Up			
U-Turn			
Skidding			
Overtaking			
Weaving			
Wrong Side			
Crowded Off Road			
Evasive Action			

Other

TOWING COMPANY NAME/PHONE

Passenger Injuries:

of Passengers in Your Car:

of Passengers in Other Driver's Car:

Seatbelts:

RESPONDING POLICE INFORMATION

Name:

Badge Number:

Unit Information:

Phone:

WITNESS INFORMATION

Name:

Address:

Phone:

Email:

Statement:

DESCRIBE ACCIDENT IN OWN WORDS

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SKETCH THE ACCIDENT SCENE: