

ACCIDENT SCENE

Instructions for Accident Diagram

Fill in dotted lines to correspond with road at accident site. Show position of all vehicles, pedestrians, etc., as follows:

Your vehicle



1

Other vehicle(s)



2

Numbered successively.

Pedestrian



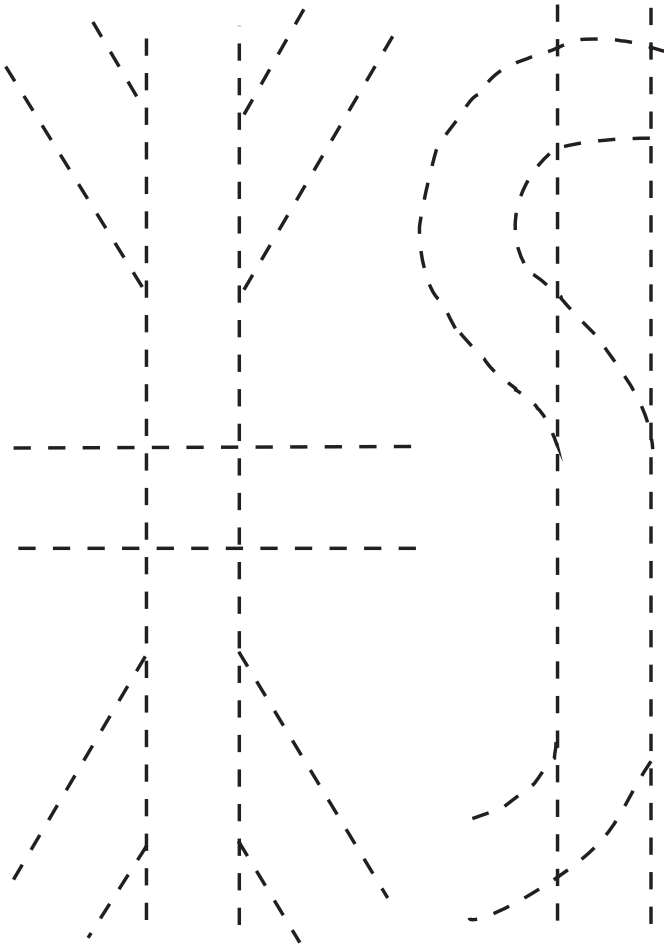
Traffic signal



Traffic sign



(indicate type)



Signature _____

Date _____

DRIVER'S ACCIDENT REPORTING KIT

To Be Completed at Accident Scene

Driver's Name _____ Age _____

License No. _____

Phone No. _____

Vehicle Owner / Home Terminal _____

Equipment No. _____ Tractor: _____ TLR: _____

A. DATE, TIME, PLACE

Date _____ : Time _____ AM; _____ PM _____

In _____

(City or Town) (County) (State)

On _____

(Street or Highway)

At _____

(Street Address or Intersection)

Distance and

Direction from: _____

(Nearest community junction, etc.)

☐ Open Country

☐ Business-Shopping

☐ Residential

☐ Manufacturing-Industrial

☐ Other (Describe) _____

B. WITNESSES

Persons seeing the accident will be of service to our driver by giving their names and addresses.

NAME _____

Address _____ Phone _____

NAME _____

Address _____ Phone _____

License number and descriptions of first vehicles at scene.

INVESTIGATING OFFICER

Name _____

Badge No. _____ Dept. _____

Citation: You _____ Other _____

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C. THOSE INVOLVED**COMPANY VEHICLE (VEHICLE #1)**

Make &
Model _____
Vin. _____ Fleet
No. _____ No. _____
Tag No. & State _____

OTHER VEHICLE (VEHICLE #2)

Make &
Model _____
Tag No. &
State _____
Driver _____
Address _____
Driver's License No. _____
Name, address and phone of owner (if not the driver) _____

Insurance Co. _____ Policy No. _____

OTHER VEHICLE (VEHICLE #3)

Make &
Model _____
Tag No. &
State _____
Driver _____
Address _____
Driver's License No. _____
Name, address and phone of owner _____

Insurance Co. _____ Policy No. _____

If other vehicles attach all information.

INJURED PERSONS

Number of persons injured _____ Killed _____
Name _____ Age _____
Address _____
Injuries _____
Where taken _____
Name _____ Age _____
Address _____
Injuries _____
Where taken _____
Estimate of property damage \$ _____

D. TYPE OF ACCIDENT

☐ Collision with Other Vehicle ☐ Collision with Fixed Object

	Veh. 1	Veh. 2	Veh. 3
<input type="checkbox"/> Ran off Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overturn in Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mechanical Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Loading or Unloading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Boarding / Alighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant fell out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant injured inside vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____			

PEDESTRIAN ACTION

Crossing at Intersection ☐ Between Intersections ☐
With Signal ☐ Against Signal ☐
No Signal ☐ Diagonally ☐
Walking in Roadway ☐ Sidewalk ☐ No Sidewalk ☐
With Traffic ☐ Against Traffic ☐
Other (Describe): _____

E. VEHICLE MOVEMENT

	Veh. 1	Veh. 2	Veh. 3
Straight Ahead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slowing or Stopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stopped in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting from Curb or Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U-Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skidding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overtaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrong Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowded off Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evasive Action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

F. VEHICLE CONDITION

MECHANICAL CONDITION

	Veh. 1	Veh. 2	Veh. 3
No Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tires / Wheels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Couplings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Windshield / Windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

G. ROADWAY CONDITIONS AND CONTROLS

- | | |
|--|--|
| <input type="checkbox"/> Not at Intersection | <input type="checkbox"/> Bridge / Overpass |
| <input type="checkbox"/> Street Intersection | <input type="checkbox"/> Underpass |
| <input type="checkbox"/> Drive or Alley | <input type="checkbox"/> Private property |
| <input type="checkbox"/> Crosswalk | <input type="checkbox"/> Other off-street |
- Other (describe) _____
- | | | |
|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Not Divided | <input type="checkbox"/> Divided | <input type="checkbox"/> Limited Access |
|--------------------------------------|----------------------------------|---|
- ☐ No. of Lanes 2 3 4 6 _____
(Specify)

ROAD SURFACE

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Lanes Marked | <input type="checkbox"/> Unmarked |
| <input type="checkbox"/> Concrete | <input type="checkbox"/> Gravel |
| <input type="checkbox"/> Blacktop | <input type="checkbox"/> Other Unpaved |
- ☐ Metal Grating (Bridge)
☐ Other (specify) _____
- | | |
|-------------------------------------|---|
| <input type="checkbox"/> No Defects | <input type="checkbox"/> Mud |
| <input type="checkbox"/> Dry | <input type="checkbox"/> Loose Material |
| <input type="checkbox"/> Wet | <input type="checkbox"/> Cracks, holes, etc. |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Fresh Oil |
| <input type="checkbox"/> Snow | <input type="checkbox"/> Under construction or repair |
- ☐ Other (describe) _____
- | | | | | |
|-----------------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Straight | <input type="checkbox"/> Level | <input type="checkbox"/> Hills | <input type="checkbox"/> Steep | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Curve | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> Sharp | <input type="checkbox"/> Moderate |

TRAFFIC CONTROLS

- | | |
|---|--|
| <input type="checkbox"/> Traffic Light | <input type="checkbox"/> RR Crossing Signal / Gate |
| <input type="checkbox"/> Stop Sign | <input type="checkbox"/> No Traffic Control |
| <input type="checkbox"/> Yield Sign | <input type="checkbox"/> Posted Speed Limit _____ |
| <input type="checkbox"/> Police Officer | <input type="checkbox"/> Other _____ |
- Were controls operating? ☐ Yes ☐ No

WEATHER CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> Clear | <input type="checkbox"/> Daylight |
| <input type="checkbox"/> Snow | <input type="checkbox"/> Dawn |
| <input type="checkbox"/> Sleet | <input type="checkbox"/> Sunset |
| <input type="checkbox"/> Fog | <input type="checkbox"/> Dark - road lighted |
| <input type="checkbox"/> Rain | <input type="checkbox"/> Dark - road unlighted |
| <input type="checkbox"/> Other (specify) _____ | |

H. PROPERTY DAMAGE

Point of Impact

	Veh. 1	Veh. 2	Veh. 3
Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

Cargo Weight / Type: _____

Cargo Damage: _____

Other Property Damage: _____

I. MISCELLANEOUS INFORMATION

Time you reported for duty: _____

Total preceding hours off duty: _____

Hours since last sleep at time of going on duty: _____

Hours on duty at time of accident: _____

Total rest-stop time since going on duty: _____

Total other time, loading, etc.: _____
