

FORM

YOUR INFORMATION

Your name:

Your driver's license number:

Your full address and phone number:

Vehicle owner's name (if different from driver):

Owner's full address and phone number (if different from driver):

YOUR VEHICLE INFORMATION

Year make and model:

Mileage:

Color:

Plate number and state:

Vehicle identification number (VIN):

Was the vehicle in proper driving condition?

YOUR INSURANCE INFORMATION

Insurance company:

Phone number:

Policy number and expiration date:

YOUR PASSENGERS

List the full name and position of every passenger (front, back seat):

Describe any passenger injuries:

THE OTHER DRIVER'S INFORMATION

<i>Other driver's name:</i>	<i>Other driver's license number:</i>	<i>Other driver's full address and phone number:</i>
<i>Vehicle owner's name (if different from other driver):</i>	<i>Owner's full address and phone number (if different from other driver):</i>	

OTHER VEHICLE INFORMATION

<i>Year make and model:</i>	<i>Mileage:</i>	<i>Color:</i>
<i>Plate number and state:</i>	<i>Vehicle identification number (VIN):</i>	<i>Was the vehicle in proper driving condition?</i>

OTHER DRIVER'S INSURANCE INFORMATION

<i>Insurance company:</i>	<i>Phone number:</i>	<i>Policy number and expiration date:</i>
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OTHER VEHICLE'S PASSENGERS

<i>List the full name and position of every passenger in the other vehicle (front, back seat):</i>	<i>Describe any passenger injuries:</i>
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ACCIDENT INFORMATION

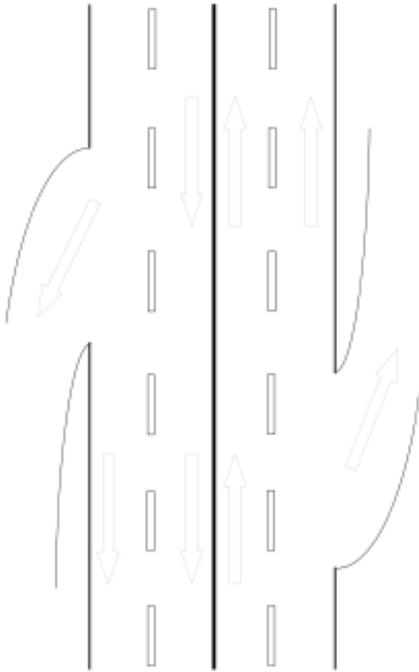
Date and time:	Estimated speed of your vehicle (mph):	Is your vehicle drivable? <input type="checkbox"/> Yes <input type="checkbox"/> No
Location (city, crossroads, landmarks)	Estimated speed of the other vehicle (mph):	Is the other vehicle drivable? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the damage to your vehicle:		Describe the damage to the other vehicle:
Road conditions: <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Clear <input type="checkbox"/> Debris <input type="checkbox"/> Other:	Weather conditions: <input type="checkbox"/> Fog <input type="checkbox"/> Snow <input type="checkbox"/> Hail <input type="checkbox"/> Rain <input type="checkbox"/> Other:	Lighting conditions: <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Other:
Other details of the accident:		

COLLISION WITNESSES

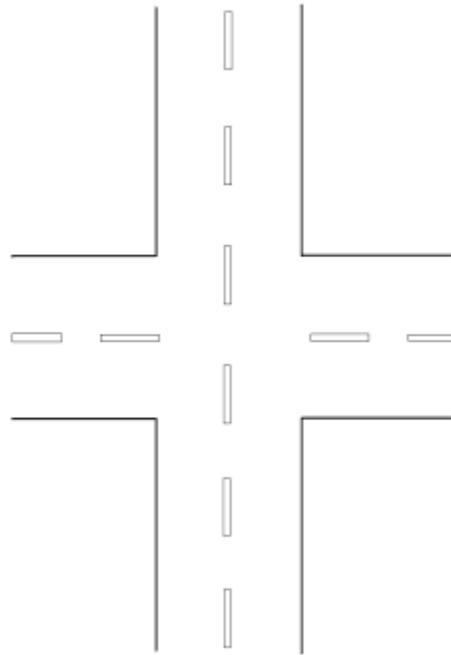
Name:	Phone number:	Address:
Email:		
Name:	Phone number:	Address:
Email:		
Name:	Phone number:	Address:
Email:		

ACCIDENT DIAGRAMS (DRAW OUT)

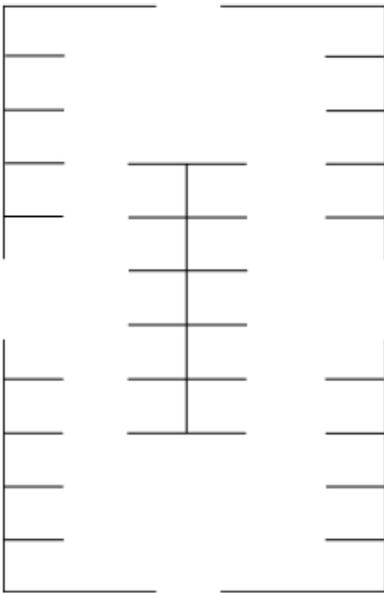
Highway ramp



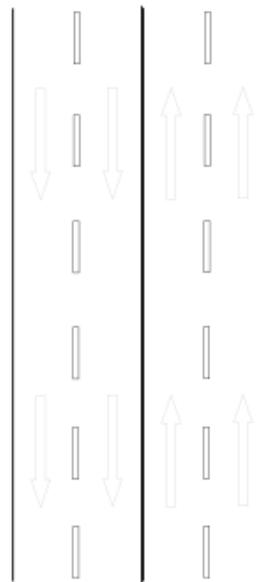
Four-way intersection



Parking lot



Two-lane highway or road



Legend (Please use the following symbols to complete the collision diagram.)

Your Vehicle



Other Vehicles (Numbered Successively)



Pedestrian



Traffic Signal



Traffic Sign (Indicate Type)



ATTENDING POLICE OFFICER*Name:**Badge number:**Phone number:***TOW TRUCK OPERATOR***Driver's name:**Company:**Truck number:**Phone number:**Vehicle towed to:**Cost:*