

Investigator's Motor Vehicle Accident Report

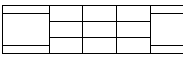
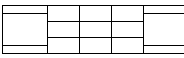
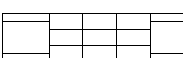
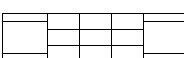

<b>Total Number of Vehicles</b>		Local No./ District		Agency Case No.		<b>HIT &amp; RUN?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		L											
A/1	<b>DATE OF ACCIDENT</b>	M M / D D / Y Y Y Y S M T W T H F S (In Military Time)						<b>TIME OF ACCIDENT</b>		<b>STATE USE ONLY</b>									
A/2	<b>PLACE OF ACCIDENT</b>	COUNTY						<b>POLICE NOTIFIED</b>		LATITUDE									
B		CITY						PRIVATE PROPERTY? <input type="checkbox"/> YES <input type="checkbox"/> NO		LONGITUDE									
B	<b>ROAD ON WHICH ACCIDENT OCCURRED</b>	STREET/ HIGHWAY NO.						ONE-WAY STREET? <input type="checkbox"/> YES <input type="checkbox"/> NO		-----									
C	<b>DISTANCE FROM MILEPOST</b>	FEET		N S E W		OF MILEPOST		HIGHWAY NO.		SHOULD LOCATION HAVE ENGINEERING STUDY? <input type="checkbox"/> YES <input type="checkbox"/> NO									
D	<b>IF AT INTERSECTION</b>				<b>IF NOT AT INTERSECTION</b>														
D	NAME OF INTERSECTING ROADWAY				<input type="checkbox"/> FEET <input type="checkbox"/> MILES		N S E W		OF NEAREST STREET, BRIDGE, RAILROAD CROSSING										
V1/M	<b>IF ACCIDENT WAS OUTSIDE CITY LIMITS, INDICATE DISTANCE FROM NEAREST TOWN</b>																		
V2/M	MILES	N S E W		AND MILES		N S E W		OF NEAREST CITY OR TOWN											
E	<b>R. WORK ZONE CODES</b>	R1	R2	R3	R4	<b>S. PEDESTRIAN CLASSIFICATION CODES</b>	S1	S2	S3	S4	S5-a	S5-b	S6-a	S6-b	<b>CONTINUATION FORMS ATTACHED</b> (Fill in all that apply) <input type="checkbox"/> NONE <input type="checkbox"/> TRUCK & BUS <input type="checkbox"/> CONTINUATION				
<b>VEHICLE NO. 1</b>																			
F	<b>DRIVER'S LICENSE NO.</b>											<b>STATE (Of License)</b>		<b>SEX</b> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE					
V1/N	DRIVER						PHONE				LOCAL NO.								
V2/N	DRIVER ADDRESS						CITY, STATE, ZIP				<b>DATE OF BIRTH</b> MM / DD / YYYY		V1/1						
V1/O	OWNER						PHONE				LOCAL NO.								
V1/2	OWNER ADDRESS						CITY, STATE, ZIP				<b>CITATION</b> <input type="checkbox"/> PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		CITATION NO.						
H	<b>LICENSE PLATE NO.</b>											<b>YEAR (Plate Expires)</b>		<b>STATE (Of Plate)</b>			V1/3		
V1/O	<b>VEHICLE</b>	YEAR	MAKE		MODEL		BODY STYLE		COLOR		ESTIMATED DAMAGE					V1/4			
V1/5	<b>VEHICLE ID NO. (VIN)</b>											INSURANCE COMPANY					V1/5		
V2/O	TOWED TO						TOWED BY				POLICY NO.					V1/6			
<b>VEHICLE NO. 2</b>																			
I	<b>DRIVER'S LICENSE NO.</b>											<b>STATE (Of License)</b>		<b>SEX</b> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE					
V1/P	DRIVER						PHONE				LOCAL NO.					V2/1			
V2/P	DRIVER ADDRESS						CITY, STATE, ZIP				<b>DATE OF BIRTH</b> MM / DD / YYYY		V2/2						
V2/3	OWNER						PHONE				LOCAL NO.								
J	OWNER ADDRESS						CITY, STATE, ZIP				<b>CITATION</b> <input type="checkbox"/> PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		CITATION NO.						
V1/Q	<b>LICENSE PLATE NO.</b>											<b>YEAR (Plate Expires)</b>		<b>STATE (Of Plate)</b>			V2/4		
V2/Q	<b>VEHICLE</b>	YEAR	MAKE		MODEL		BODY STYLE		COLOR		ESTIMATED DAMAGE					V2/5			
V2/6	<b>VEHICLE ID NO. (VIN)</b>											INSURANCE COMPANY					V2/6		
K	TOWED TO						TOWED BY				POLICY NO.								
<b>Complete this section for all injured persons</b> (Complete a continuation report, if more than three were injured)											<b>DATE OF BIRTH</b> (MM / DD / YYYY)		1	2	3	4	5	<b>SEX</b> M F	
VEH. #	NAME						ADDRESS						Seat Position	Eject	Body Region	Injury Sev.	Trans.		
	LOCAL NO.		MEDICAL FACILITY NAME			EMS SERVICE NAME			EMS RUN REPORT NO.										
VEH. #	NAME						ADDRESS												
	LOCAL NO.		MEDICAL FACILITY NAME			EMS SERVICE NAME			EMS RUN REPORT NO.										
VEH. #	NAME						ADDRESS												
	LOCAL NO.		MEDICAL FACILITY NAME			EMS SERVICE NAME			EMS RUN REPORT NO.										

**THE FOLLOWING INFORMATION IS REQUIRED FOR ALL ACCIDENTS**

 Indicate North by Arrow	Investigation made at scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	INDICATE BY DIAGRAM WHAT HAPPENED	Agency Case No.:
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**DESCRIPTION OF ACCIDENT BASED ON OFFICER'S INVESTIGATION**

<b>PROPERTY</b>	OBJECT DAMAGED	OWNER NAME	ADDRESS	PHONE	APPROX. COST OF DAMAGE
	OBJECT DAMAGED	OWNER NAME	ADDRESS	PHONE	APPROX. COST OF DAMAGE
<b>WITNESSES</b>	NAME				PHONE
	NAME				PHONE

VEHICLE MOVEMENT BEFORE COLLISION					POINT OF IMPACT AND MOST DAMAGED AREA <i>(Enter numbers for each vehicle)</i>				AIRBAG DEPLOYED		RESTRAINT USE		TOTAL OCCUPANTS		VEH 1	VEH 2	
VEH. NO.	N	S	E	W	ROAD OR HIGHWAY NAME				VEHICLE 1		VEHICLE 1		ALCOHOL TESTING	Driver No. 1	Driver No. 2	Pedestrian	
1													Y			Y	
2													N			N	
1									1 Deployed – front 2 Deployed – side 3 Deployed – both front/side 4 Not deployed 5 Not applicable/No airbag available 6 Unknown		1 None used – vehicle occupant 2 Lap & shoulder belt used 3 Shoulder belt only used 4 Lap belt only used 5 Child safety seat used 6 Child booster seat used 7 Helmet used 8 Restraint use unknown		BAC LEVEL				
2													00 None                      11 Total (all areas) 09 Top & windows      12 Other 10 Undercarriage		1 Neither alcohol nor drugs suspected 2 Yes – alcohol suspected 3 Yes – drugs suspected 4 Yes – alcohol & drugs suspected 5 Unknown		ALCOHOL/ DRUGS SUSPECTED
01 Essentially straight ahead 02 Backing 03 Changing lanes 04 Overtaking/ Passing 05 Turning right 06 Turning left 07 Making U-turn 08 Entering traffic lane 09 Leaving traffic lane 10 Parked 11 Slowing or stopped in traffic 12 Other 13 Unknown																	
OFFICER NO.					TROOP/ TEAM/ BEAT				DEPARTMENT					Photographs taken? <input type="checkbox"/> YES <input type="checkbox"/> NO			
INVESTIGATOR NAME (Print or Type)					INVESTIGATOR SIGNATURE					DATE OF REPORT							