

MOTOR VEHICLE ACCIDENT REPORT
STATE OF GEORGIA

The operator of every motor vehicle which is in any manner involved in an accident within this State, in which any person is killed or injured or in which damage to the property of any one person, including himself, to an extent of \$250.00 or more is sustained, must make a report of the accident on this form within 10 days from the date of the accident.

ALL REPORTS ARE CONFIDENTIAL AND CANNOT BE USED AS EVIDENCE IN AN ACTION AT LAW TO RECOVER DAMAGES.

INSTRUCTIONS—RULES—READ CAREFULLY! Fill Out COMPLETELY to Avoid SUPPLEMENTARY Report

- 1. Answer all questions to the best of your knowledge. If unable to answer any question, mark "not known."
2. Give exact time of accident (date, day and hour).
3. Under "Location of Accident" show sufficient information to locate exact scene of the accident.
4. Print or type all names and addresses.
5. Sign the report in the space provided on reverse side.
6. Report must be complete as to exact names, birth dates and drivers license numbers.
7. Use a second report form or a sheet of plain paper of the same size to report additional vehicles, injured persons, or witnesses, or any other information for which there is insufficient space.

IMPORTANT: If you had an automobile liability policy at the time of the accident, secure from your agent or company a notice of insurance (Form SR-21) and attach to this report or have your agent or insurance company mail such form direct to the Bureau of Safety Responsibility.

TIME Date of Accident Day of Week Hour A.M. P.M. Weather: Clear, Raining, Fog, Etc.

LOCATION PLACE WHERE ACCIDENT OCCURRED: County City, Town or Township
If accident was outside city limits indicate distance from nearest town. Use two distances and two directions if necessary.
ROAD ACCIDENT OCCURRED ON: Give name of street or highway number. (U.S. or State). If no highway number, identify by name.

VEHICLES YOUR VEHICLE NUMBER 1 Vehicle License Plate Approximate cost to repair vehicle \$
Year Make Type (sedan, truck, taxi, bus, etc.) Year State Number
Driver Print or Type Full Name Street or R.F.D. City and State
Driver's Occupation Driver's License Driver's Birth Date Age Sex
Owner Print or Type Full Name Street or R.F.D. City and State Owner's Birth Date Month Day Year
Parts of Vehicle Damaged Driveable: Yes No Owner's Driver's License State Number
Is this vehicle covered by automobile liability insurance? IF YES TO EITHER SHOW INSURANCE COMPANY
If vehicle not covered, did driver have liability policy applicable? Show Policy Number Here Name Address

OTHER VEHICLE NUMBER 2 Vehicle License Plate Approximate cost to repair vehicle \$
Year Make Type (sedan, truck, taxi, bus, etc.) Year State Number
Driver Print or Type Full Name Street or R.F.D. City and State
Driver's Occupation Driver's License Driver's Birth Date Age Sex
Owner Print or Type Full Name Street or R.F.D. City and State Owner's Birth Date Month Day Year
Parts of Vehicle Damaged Driveable: Yes No Owner's Driver's License State Number
Is this vehicle or driver covered by automobile liability insurance? IF YES SHOW NAME OF INSURANCE COMPANY

DAMAGE TO PROPERTY OTHER THAN VEHICLE Approximate cost to repair \$
NAME AND ADDRESS OF OWNER OF DAMAGED PROPERTY NAME OBJECT AND STATE NATURE OF DAMAGE

3rd VEHICLE

VEHICLE NUMBER 3 (If third vehicle involved)

Vehicle License Plate _____ Approximate cost to repair vehicle \$ _____

Year Make Type (sedan, truck, taxi, bus, etc.) _____ Year State Number _____

Driver _____
 Print or Type Full Name _____ Street or R.F.D. _____ City and State _____

Driver's Occupation _____ Driver's License _____ Driver's Birth Date _____ Age _____ Sex _____
 Carpenter, Sales Clerk, Etc. State Number Mo. Da. Yr.

Owner _____
 Print or Type Full Name _____ Street or R.F.D. _____ City and State _____
 Owner's Birth Date _____ Month _____ Day _____ Year _____

Parts of Vehicle Damaged _____ Driveable: Yes No Owner's License _____ State _____ Number _____

Is this vehicle or driver covered by automobile liability insurance? Yes No } IF YES SHOW NAME OF INSURANCE COMPANY }

INJURED

Name _____ Address _____ Driver } In Vehicle
 Passenger } No. _____
 Pedestrian
 Specify other _____

Age _____ Sex _____ Race _____ Injured taken to _____

Did injured die? _____ Nature and extent of injuries _____ Attending Doctor _____

Name _____ Address _____ Driver } In Vehicle
 Passenger } No. _____
 Pedestrian
 Specify other _____

Age _____ Sex _____ Race _____ Injured taken to _____

Did injured die? _____ Nature and extent of injuries _____ Attending Doctor _____

Total Injured

Light Conditions Daylight Dawn or dusk Darkness

What Pedestrian Was Doing

Pedestrian was going (check one) N S E W Across or into _____ From _____ To _____
 (Street name, highway no.) (N.E. corner to S.E. corner, or west side to east side, etc.)

Crossing or entering at intersection Walking in roadway—with traffic Pushing or working on vehicle Other in roadway
 Crossing or entering not at intersection Walking in roadway—against traffic Other working in roadway Not in roadway
 Getting on or off vehicle Standing in roadway Playing in roadway

What Drivers Intended To Do: (Check one for each driver)

Driver 1 2 3	Driver 1 2 3	Driver 1 2 3	Driver 1 2 3
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Go straight ahead	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make left turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start in traffic	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain stopped in traffic lane
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overtake and pass	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make U turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Start from parked position	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Remain parked
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Make right turn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow or stop	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Get out of parked or stopped vehicle

Witnesses:

Name _____ Address _____ Age _____ approximate

Name _____ Address _____ Age _____ approximate

Investigated by _____ Badge No. _____ Department _____
 Name of law enforcement officer(s) Name of city department, county, state, etc.

NOT INVESTIGATED BY LAW ENFORCEMENT AGENCY

DESCRIBE WHAT HAPPENED:

Refer to vehicles by number. _____
 If more space is needed, use another report form or a sheet of plain paper of the same size. _____

SIGNATURE _____ ADDRESS _____ DATE _____

Signature of person submitting report is required—complete both sides of this form