



STATE OF WASHINGTON
VEHICLE ACCIDENT REPORT

Date of Accident (MM/DD/YYYY)

Time AM
 PM

INSTRUCTIONS: This report must be mailed* within two working days to the following offices:

- ① Department of Enterprise Services
Office of Risk Management
1500 Jefferson Street SE /POB 41466
Olympia, Washington 98504-1466
- ② Safety/Risk Management
Office of Reporting Agency

*Scanned form can be e-mailed to desmiriskmanagement@des.wa.gov

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|--|--|-----------------|---|------------------|--------------------|---|-------------------|---|------------|--------|
| STATE EMPLOYEE VEHICLE NO. 1 | Name | | Age | Employing Agency | | | Position | | | |
| | Business Address | | Zip | Business Phone | | Email | | Was vehicle being used on Official State Business <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Operator's License No. | | License Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No | | If Yes, Indicate | | | Have you had a previous accident while driving on state business? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | License No. | Year | Make | Body Type | Where Located | | No. of Passengers | Est. Repair Cost | | |
| | Owning Agency | | Describe Damages Fully (Parts, type, and extent of damage) | | | | | | | |
| If Privately Owned, Name and Address of Owner (If State Owned, Equipment No. Only) | | | | | | | Insurer | | | |
| OTHER VEHICLES | Owner Car No. 2 | | Phone | | Owner Car No. 3 | | Phone | | | |
| | Address | | City | Zip | Address | | City | Zip | | |
| | Driver | | Age | Phone | | Driver | | Age | Phone | |
| | Address | | City | Zip | Address | | City | Zip | | |
| | Driver's License No. | | Vehicle License No. | | | Driver's License No. | | Vehicle License No. | | |
| | Vehicle Make | | Year | Body Type | | Vehicle Make | | Year | Body Type | |
| | Name of Passengers | | | | Name of Passengers | | | | | |
| | Repair Cost | Describe Damage | | | | Repair Cost | Describe Damage | | | |
| | Insurance Company | | | Policy No. | | Insurance Company | | | Policy No. | |
| | What was Damaged? | | | | | | | Repair Cost | | |
| OTHER PROPERTY | Name and Address of Owner | | | | | | | City | Zip | Phone |
| | Name and Address | | | | Extent of Injury | | Age | Veh. 1 | Veh. 2 | Veh. 3 |
| INJURED PARTIES | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| WITNESSES | Name | | Address | | City | Zip | Phone | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| OTHER | Police Investigate? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Which Division (Sheriff, WSP, City) | | | Citation Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Have you filed a Collision Report Form WSP 161 As Required by Law? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | Issue To <input type="checkbox"/> You <input type="checkbox"/> Veh. 2 <input type="checkbox"/> Veh. 3 | | | | |

| | | | | | | |
|--|---------------------|---------------------------|--|--|--|--|
| Location | | Or Near Intersection of | | | | |
| City/County | | Type of Accident | <input type="checkbox"/> Front to Rear <input type="checkbox"/> Broadside | <input type="checkbox"/> Head-On <input type="checkbox"/> Sideswipe | <input type="checkbox"/> Parked Car <input type="checkbox"/> Bike - Car | <input type="checkbox"/> Pedestrian <input type="checkbox"/> Hit Object |
| Information Regarding Accident | No. 1, Your Vehicle | No. 2, Other Party (Name) | | No. 3, Other Party (Name) | | |
| 1. If pedestrian, where was he/she (crosswalk, etc.)? | | | | | | |
| 2. Road conditions (dry, glare, icy, rain, snow, etc.)? (Gravel, blacktop, etc.) | | | | | | |
| 3. At what distance danger was first noticed? | | | | | | |
| 4. Speeds at time danger was first noticed? | | | | | | |
| 5. Speeds at time of accident? | | | | | | |
| 6. What warning signals were given? | | | | | | |
| 7. Obstruction to vision (weather and other)? | | | | | | |
| 8. Lights On? Wipers On? Windows Fogged? | | | | | | |
| 9. Had any party been drinking? Who? | | | | | | |

Describe in Detail What Happened (Use additional paper if necessary)

| | | | |
|--|--|---|----------------------------------|
| <input type="checkbox"/> Straight Road <input type="checkbox"/> Curve – R or L <input type="checkbox"/> Level | <input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill | <input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane | <p>Mark Damaged Areas</p> |
| <p>Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.</p> <p>IMPORTANT If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.</p> | <p>Indicate points of compass N. E. S. W.</p> | | |
| Signature (Driver) | Date | Signature (Supervisor) | Date |