AUTO ACCIDENT REPORT FORM *Keep In Your Glove Box*

POLICY HOLDER

Name of Driver:_____ Emp. No:_____
Address:_____ Date Reported:_____
_____ Phone No:_____
Drivers License No:_____ Exp. Date:_____
Foreman:_____Supervisor:_____ Regional VP:_____

DETAILS OF ACCIDENT

Date:_____ 20_____Time:_____am/pm_____ Job No:_____
Location:_____ Weather Conditions_____
Police Report Made To:_____ Conditions of Road:_____
Any Citations Issued:_____ City/Officers No:_____
What Charge:_____ AgainstWhom:_____
Drug Screen:___No___Yes If Yes, List Employee Name_____

INSURED VEHICLE INFO

Equipment: Year_____Make:_____ Equipment No:_____
Equipment: Year_____Make:_____ Equipment No:_____
Rental:___No___Yes If yes, Rental Company Name:_____ Phone No:_____

CARGO LOSS

Type of loss:_____
Present Location:_____

DAMAGE TO VEHICLE OF POLICY HOLDER

Description of Damage: _____ **COLLISION:**_____
_____ **FIRE:** _____
_____ **THEFT:**_____
_____ **OTHER:**_____
Present Location of Insured'sVehicle?_____
Insureds Estimate of Damage: _____

DAMAGE TO PROPERTY OF OTHERS

Owner of Vehicle (1):_____ Driver of Vehicle(2):_____
Address:_____ Year and Make of Vehicle:_____
Licence No:_____Phone_____ License No:_____
Damage:_____ Policy No:_____
Insurance Company:_____
Owner of Vehicle:_____ Driver of Vehicle(3):_____
Address:_____ Year and Make of Vehicle:_____
Licence No:_____Phone_____ License No:_____
Damage:_____ Policy No:_____
Insurance Company:_____

INJURED

(1)	(2)	(3)
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Phone:_____Age:_____	Phone:_____Age:_____	Phone:_____Age:_____
Injuries:_____	Injuries:_____	Injuries:_____
Doctor:_____	Doctor:_____	Doctor:_____
Hospital:_____	Hospital:_____	Hospital:_____

OCCUPANTS OF INSURED VEHICLE

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

PLEASE ATTACH PICTURES TO REPORT

Continued

OCCUPANTS OF OTHER VEHICLE:

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

IMPORTANT: INDEPENDENT WITNESSES: (Include names of bystanders who saw accident, or heard any statements made)

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

THE ACCIDENT	POLICYHOLDER'S VEHICLE: SPEED: Before The Accident:_____m/h At Instant of Accident:_____per hour LIGHTS:_____ (ON - OFF - DIM - BRIGHT) Which Side of Road_____Warning:_____ Direction Travelled:_____	OTHER VEHICLE: SPEED: Before The Accident:_____m/h At Instant of Accident:_____per hour LIGHTS:_____ (ON - OFF - DIM - BRIGHT) Which Side of Road_____Warning:_____ Direction Travelled:_____

DRIVER'S STATEMENT OF HOW ACCIDENT OCCURRED:

What part of your vehicle and what part of other car were first in touch?_____

Whom do you consider is responsible?_____

ACTION TO BE TAKEN

□ Verbal □ Probation □ Dismissal □ Information Only

□ Written □ Suspension □ Other _____

Comments:_____

_____

_____

By signing this document, you acknowledge that you have read and understand the information contained herein.

Date Signed:_____Signature of Driver:_____

Date Signed:_____Signature of Manager_____

Attach a diagram to further explain accident, show points of compass, name of streets, direction and position of vehicles .