



OREGON TRAFFIC COLLISION AND INSURANCE REPORT

Tear this sheet off your report, read and carefully follow the directions.

Oregon law requires the driver of a motor vehicle involved in a collision that happened in Oregon to submit a report to DMV within 72 hours when any of these are true:

- Injury or death resulted from the collision
- Damage to anyone's property other than a vehicle involved in the collision is over \$2,500.
- Damage to your vehicle is over \$2,500
- Damage to any vehicle is over \$2,500 AND any vehicle is towed from the scene.

If you are not able to file a report within 72 hours of the collision, submit one as soon as possible. If you do not file a report when required, Oregon law requires DMV to suspend your driving privileges. **You still need to file a report with DMV even if law enforcement files a police report. When required to report, you must file a report even if you are licensed in another state or you are not an Oregon resident.** DMV does not determine fault in a collision, but we are required by law to post the collision to the driving record of drivers required to report. **If you have questions, please call the DMV Crash Reporting Unit at (503) 945-5098.**

INSTRUCTIONS

PRINT OR TYPE ALL INFORMATION. (Use black or dark blue ink and press firmly.)

- Complete both sides of the form.
- If additional vehicles were involved in the collision, complete the attached *Supplemental Report* (Form 735-32B). Or, on a blank piece of paper, write all the information as requested in Section 4 — the "Other Vehicle" Section.
- DMV will verify the insurance information you submit. DMV may suspend your driving privileges if you do not complete the insurance section.

SECTION 1

DATE, LOCATION AND TIME — Clearly identify the date, location and time of the collision. This information is critical for processing your report. If you don't know the county, contact any local law enforcement agency for help.

SECTION 2

Your vehicle is Vehicle #1. Complete ALL fields. **Write your insurance company name (not agent), policy number, and vehicle identification number (VIN).** DMV may suspend your driving privileges if you fail to give complete insurance and vehicle information.

SECTION 3

Check all statements that apply. Principal purpose of driving and being paid to drive does not include driving to a destination to perform a service. Property includes, but is not limited to, fixed or real property, landscaping, signs, parked vehicles, and animals.

COMMERCIAL MOTOR VEHICLE OPERATORS: In addition to this report, Oregon Administrative Rule requires that **Form 735-9229, Motor Carrier Collision Report, MUST** be filed within 30 days of a commercial motor vehicle collision when there is a FATALITY, INJURY (requiring treatment away from the scene), or when a vehicle is TOWED from the scene because of disabling damage. Form 735-9229 (attached on back) MUST be submitted with *Oregon Traffic Collision and Insurance Report* (Form 735-32) to DMV.

You may file the Motor Carrier Collision Report online at: www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/

SECTION 4

OTHER VEHICLE (# 2) — Completion of this information will help DMV match all drivers' collision reports more efficiently. If additional vehicles were involved in the collision, complete attached *Supplemental Report* (Form 735-32B).

SECTION 5

DESCRIPTION AND SIGNATURE — Describe what happened. It is important for you to sign and date the form.

COMPLETING AND FILING REPORT

HOW TO SUBMIT A REPORT TO DMV:

- Online at DMV2U.Oregon.gov (scan QR code on this page)
- Fax to 503-945-5267
- Mail to DMV Crash Reporting Unit 1905 Lana Ave NE, Salem, Oregon 97314
- Deliver to a DMV field office



Keep a copy of the report and documentation that shows when you submitted your report to Oregon DMV. Under ORS 802.220(5), DMV is not authorized to provide you with a copy of the report that you file. If submitting by:

- Fax, many fax machines provide the option to generate a fax confirmation report. Save that report.
- DMV field office, request and save that receipt.

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY CANNOT REQUIRE REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

TOTALED VEHICLE NOTICE

DEFINITIONS AND INSTRUCTIONS FOR TOTALED VEHICLES

IF YOUR COLLISION HAS RESULTED IN A "TOTALED" VEHICLE, YOU ARE REQUIRED BY LAW TO FOLLOW APPROPRIATE INSTRUCTIONS IN THIS NOTICE.

DEFINITION OF "TOTALED" VEHICLE

"Totaled Vehicle" or "Totaled" as defined in Oregon law (ORS 801.527) means:

- A vehicle that is declared a total loss by an insurer who is obligated to cover the loss or a vehicle that the insurer takes possession of or title to.
- A vehicle that has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80% of the retail market value prior to the damage. "Retail market value" is defined as the amount shown in publications used by financial institutions (banks or lenders) in this state.
- A vehicle that is stolen, if it is not recovered within 30 days of theft and the loss is not covered by an insurer. **In this situation, you must notify DMV within 60 days of the theft.**

▼ FOLLOW THESE INSTRUCTIONS IF YOUR VEHICLE IS TOTALED ▼

If your vehicle is totaled, in addition to completing the collision report, follow the instruction that is applicable to your case. **Either:**

1. SURRENDER the title to the insurer if the damage is covered by an insurer who declares the vehicle to be a "total loss," and the insurer takes possession of the vehicle; **or**
2. SURRENDER the title to DMV and apply for salvage title if the damage is covered by an insurer who declares the vehicle to be a "total loss," but you keep possession of the vehicle; **or**
3. SURRENDER the title to DMV and apply for salvage title if the damage was not covered by an insurer and the estimated cost of repair is at least 80% of the retail market value of the vehicle before the damage; **or**
4. NOTIFY DMV that your vehicle has been totaled if, for some reason, you are unable to obtain the title for surrender. You must provide DMV with a signed statement which includes:
 - A description of the vehicle which includes the year model, make, plate number and vehicle identification number.
 - A statement indicating the vehicle has been totaled.
 - A statement that you are unable to obtain the title and why.

DO NOT SUBMIT THE TITLE WITH THE COLLISION REPORT. You can obtain the *Application for Salvage Title* Form 735-229 from any DMV office, by calling (503) 945-5000, or on-line at www.oregondmv.com. Application instructions and fee information are on the back of Form 735-229.

NOTE: It is a Class A misdemeanor with a penalty of imprisonment and/or fine if you fail to comply with the above requirements. (ORS 819.012)



OREGON TRAFFIC COLLISION AND INSURANCE REPORT

COMPLETE BOTH SIDES

Complete this form if the traffic collision was caused by the motion of a vehicle or its load and meets at least one of the reporting requirements on the front page of this form. DMV may suspend your driving privileges if you fail to report when required. Call 503-945-5098 if you have questions or need help with completing the report.

SECTION 1	COLLISION DATE (MM/DD/YY)	DAY OF WEEK <input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> TH <input type="radio"/> F <input type="radio"/> S <input type="radio"/> SN	TIME OF DAY : <input type="radio"/> AM <input type="radio"/> PM	COUNTY	DMV USE ONLY			
	ROAD ON WHICH COLLISION OCCURRED (Name of street, road or route)				MILE POST	TYPE OF COLLISION - The collision involved one or more of the following: (Mark all that apply)		
	NAME OF NEAREST INTERSECTING ROAD		<input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W		NAME OF NEAREST CITY / TOWN		<input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W	

Complete ALL fields. DMV may suspend your driving privileges if you fail to give complete information.

SECTION 2 (YOUR INFORMATION)	DRIVER'S LAST NAME	FIRST NAME	MIDDLE NAME	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X
	DRIVER'S RESIDENCE ADDRESS			CITY	STATE	ZIP CODE	<input type="checkbox"/> CHECK BOX IF ADDRESS CHANGE
	MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)			CITY	STATE	ZIP CODE	
	VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME <input type="checkbox"/> RENTAL?			CITY	STATE	ZIP CODE	
	INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS			CITY	STATE	ZIP CODE	

SECTION 3	POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER (VIN)	STATE	VEHICLE PLATE NUMBER	YEAR	MAKE & MODEL
	<p>Check all statements that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Damage to your vehicle was more than \$2500. <input type="checkbox"/> Damage to property other than a vehicle involved in the collision is over \$2500. <input type="checkbox"/> Your vehicle was towed from the scene as a result of damages. <input type="checkbox"/> You or passengers in your vehicle were injured (no matter how minor). <input type="checkbox"/> Your vehicle was parked. <input type="checkbox"/> The collision occurred while you were driving your employer's vehicle. <input type="checkbox"/> You were driving on your job and being paid for the principal purpose of driving. <input type="checkbox"/> You were being paid to drive and/or deliver persons or property. <input type="checkbox"/> You were operating a government-owned vehicle marked for transporting mail in accordance with government rules. <input type="checkbox"/> You were operating an authorized emergency vehicle. <input type="checkbox"/> The collision occurred in a work or maintenance zone. ORS 811.230 <input type="checkbox"/> A police officer came to the scene. <p>Name of police department: _____ <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State Police</p> <ul style="list-style-type: none"> <input type="checkbox"/> You were operating a commercial motor vehicle requiring you to have a commercial driver license. <input type="checkbox"/> You were transporting hazardous materials. <input type="checkbox"/> A citation was issued to you. The citation was for: _____ 					

SECTION 4 (OTHER VEHICLE #2)	DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	GENDER <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X
	DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	
	VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE	
	INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS				
	POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	STATE	VEHICLE PLATE NUMBER	YEAR

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE COLLISION, USE ATTACHED SUPPLEMENTAL REPORT (Form 735-32B).

SECTION 5	DESCRIBE WHAT HAPPENED: (IF MORE SPACE IS NEEDED, SUBMIT ADDITIONAL PAGE)

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT X	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE # () -	DATE SIGNED
IF NOT DRIVER'S SIGNATURE, STATE RELATIONSHIP	REASON DRIVER IS UNABLE TO SIGN REPORT	CONTACT PHONE NUMBER () -	



SUPPLEMENTAL REPORT OREGON TRAFFIC COLLISION

**Supplemental for more than two drivers involved in the collision.
Attach this form to your OREGON TRAFFIC COLLISION AND INSURANCE REPORT.**

COLLISION DATE (MM/DD/YY) / /	DAY OF WEEK M T W T F S S	TIME OF DAY <input type="radio"/> AM <input type="radio"/> PM	COUNTY	DO NOT WRITE IN THIS SPACE
ROAD ON WHICH COLLISION OCCURRED (Name of street, road or route)			MILE POST	

VEHICLE #3	INSURANCE COMPANY NAME (NOT AGENT)	POLICY NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE PLATE NUMBER	STATE YEAR MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE DATE OF BIRTH GENDER M F O X
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #4	INSURANCE COMPANY NAME (NOT AGENT)	POLICY NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE PLATE NUMBER	STATE YEAR MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE DATE OF BIRTH GENDER M F O X
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #5	INSURANCE COMPANY NAME (NOT AGENT)	POLICY NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE PLATE NUMBER	STATE YEAR MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE DATE OF BIRTH GENDER M F O X
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #6	INSURANCE COMPANY NAME (NOT AGENT)	POLICY NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE PLATE NUMBER	STATE YEAR MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE DATE OF BIRTH GENDER M F O X
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

VEHICLE #7	INSURANCE COMPANY NAME (NOT AGENT)	POLICY NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)	VEHICLE PLATE NUMBER	STATE YEAR MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE DATE OF BIRTH GENDER M F O X
DRIVER'S ADDRESS	CITY	STATE ZIP CODE
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE ZIP CODE

MOTOR CARRIER COLLISION REPORT

(For CMV Drivers Only)

INSTRUCTIONS: IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN **AND** A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE MOTOR CARRIER COLLISION REPORT. SUBMIT TO THE ADDRESS SHOWN ABOVE, OR USE THE LINK BELOW TO SUBMIT ONLINE. **IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER COLLISION REPORT, PLEASE CALL (503) 986-3507.**
www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/

QUALIFYING VEHICLE <input type="checkbox"/> COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF COLLISION EVEN IF GVWR IS SET UNDER 10,000 LBS) <input type="checkbox"/> HAZARDOUS MATERIAL PLACARD <input type="checkbox"/> COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS) <input type="checkbox"/> FARM TRUCK INTERSTATE (OVER 10,000 LBS.) <input type="checkbox"/> FARM TRUCK FOR-HIRE (4 OR MORE AXLES) <input type="checkbox"/> FARM TRUCK TOWING TRIPLE TRAILERS <input type="checkbox"/> FARM TRUCK (OVER 80,000 LBS.)		CRITERIA <input type="checkbox"/> ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE COLLISION) <input type="checkbox"/> ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE <input type="checkbox"/> ANY VEHICLE INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE			
MOTOR CARRIER NAME		US DOT NUMBER		AUTHORITY/FILE NUMBER	
ADDRESS		CITY		STATE	
				ZIP CODE	

DRIVER INFORMATION

DRIVER NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	LENGTH OF EMPLOYMENT YEARS MONTHS
CDL / DL NUMBER	STATE	LICENSE CLASS <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> M	EXPIRATION DATE OF MEDICAL CERTIFICATE

COMPLETE THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF THE COLLISION.

AT TIME OF THE COLLISION, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD.	TOTAL HOURS ON DUTY DURING THE PREVIOUS (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)	7 CONSECUTIVE DAYS _____ 8 CONSECUTIVE DAYS _____
DOES YOUR DRIVER HAVE A MEDICAL WAIVER <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)	

DRIVER INJURY INFORMATION

YOUR DRIVER KILLED <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR DRIVER INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO	RELIEF DRIVER KILLED <input type="checkbox"/> YES <input type="checkbox"/> NO	RELIEF DRIVER INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO	TOTAL NUMBER OF PASSENGERS ____ KILLED ____ INJURED
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OTHER DRIVER INJURY INFORMATION

TOTAL NUMBER OF OTHER DRIVERS ____ KILLED ____ INJURED	TOTAL NUMBER OF OTHER PASSENGERS ____ KILLED ____ INJURED	TOTAL NUMBER OF PEDESTRIANS ____ KILLED ____ INJURED	TOTAL NUMBER OF BICYCLISTS ____ KILLED ____ INJURED
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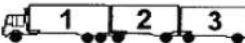
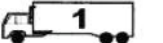




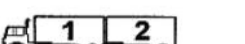

OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

MOTOR CARRIER NAME	VEHICLE LICENSE # AND STATE	DRIVER'S NAME	DRIVER'S LICENSE # AND STATE

MOTOR CARRIER VEHICLE INFORMATION

YEAR	MAKE	UNIT NUMBER	LICENSE PLATE # & STATE - TRUCK/TRACTOR/BUS	TOTAL NO. OF AXLES INCLUDING TRAILERS
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TRACTOR TYPE (SELECT APPROPRIATE TYPE)

<input type="checkbox"/> 1  Triples (tractor with 3 trailers)	<input type="checkbox"/> 5  Standard Tractor/Semi Trailer	<input type="checkbox"/> 9  Heavy Haul
<input type="checkbox"/> 2  Triples (truck with 2 trailers)	<input type="checkbox"/> 6  Straight Truck	<input type="checkbox"/> 10  Bus/Van (8 or more passenger capacity)
<input type="checkbox"/> 3  Straight truck-full trailer	<input type="checkbox"/> 7  Tractor Only	<input type="checkbox"/> 11  Auto/Pickup
<input type="checkbox"/> 4  Doubles (any)	<input type="checkbox"/> 8  Saddlemount	

TRAILER TYPE (CHECK ONE)

- VAN FLATBED TANKER CONTAINER POLE/LOG DUMP BELLY-DUMP CAR CARRIER LIVESTOCK
 MOBILE HOME TOWER PASSENGER DROP-BOX GARBAGE BULK-HOPPER MIXER SADDLEMOUNT
 WRECKER FIXED LOAD HEAVY HAUL UTILITY

COMMODITY INFORMATION

COMMODITY BEING TRANSPORTED AT TIME OF COLLISION

 WAS A HAZARDOUS COMMODITY BEING HAULED
 YES NO

 WAS HAZARDOUS MATERIAL RELEASED FROM
 THE VEHICLE CARGO (NOT A FUEL RELEASE) YES NO

HAZARD CLASS

COLLISION INFORMATION

LOCATION OF COLLISION (NEAREST CITY OR TOWN)

HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD

DIRECTION OF YOUR VEHICLE (CHECK)

 N S E W

DATE OF COLLISION

TIME

 AM
 PM

DAY OF THE WEEK (CHECK ONE)

 MON TUES WED THU FRI SAT SUN
CONDITIONS AT TIME OF COLLISION
 WEATHER (CHECK ONE) 1. CLEAR 2. RAIN 3. SNOW 4. CLOUDY 5. SLEET 6. FOG 7. OTHER _____

 ROAD SURFACE (CHECK ONE) 1. DRY 2. WET 3. SNOW 4. ICE 5. OTHER _____

 LIGHT CONDITION (CHECK ONE) 1. DAY 2. DAWN 3. DUSK 4. ARTIFICIAL LIGHTS 5. DARK 6. OTHER _____

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. YOUR VEHICLE IS ALWAYS NO.1. IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 & 3 TO CORRESPOND TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

VEHICLES 1 2 3	ACTION	VEHICLES 1 2 3	ACTION	VEHICLES 1 2 3	ACTION
	SLOWING - STOPPING		PASSING		JACKKNIFE
	STOPPED		CHANGING LANES		OVERTURN
	REAR-END		SIDESWIPE		SEPARATION OF UNITS
	BACKING		HEAD-ON		FIRE
	MAKING RIGHT TURN		SKIDDING		EXPLOSION
	MAKING LEFT TURN		VEHICLE OUT OF CONTROL		CARGO SHIFT
	MAKING U TURN		ROLL-AWAY		CARGO SPILL (HAZARDOUS)
	PROCEEDING STRAIGHT		CONTROLLED RR CROSSING		CARGO SPILL (NON-HAZARDOUS)
	INTERSECTION		UNCONTROLLED RR CROSSING		OTHER (DEER, GUARDRAIL, ETC)
	ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)		RAN OFF ROAD		

 DID YOUR VEHICLE STRIKE A PARKED VEHICLE
 YES NO

 WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE
 YES NO
DESCRIPTION OF COLLISION (BY CARRIER OR DRIVER)

NAME AND TITLE OF PERSON SIGNING REPORT

TELEPHONE NUMBER(S)

SIGNATURE | CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE

DATE

X