



OREGON TRAFFIC COLLISION AND INSURANCE REPORT

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

ONLY drivers involved in a collision resulting in any of the following MUST file a Collision & Insurance Report:

- Damage to your vehicle is over \$2500
- Injury (No matter how minor)
- Death
- Damage to any one person's property over \$2500
- Any vehicle has damage over \$2500 and any vehicle is towed from the scene as a result of damages

Oregon law requires these reports be filed within **72 hours** of the collision. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the collision to DMV, it may result in suspension of your driving privileges. **If the police department files a police report, you are still required to file your own Collision and Insurance Report with DMV. When required to report, even if you are licensed in another state, or you are not an Oregon resident, you still must file a report with Oregon DMV.** DMV does not determine fault in a collision, but does post the collision to the driving record of those drivers required to report, unless the vehicle is parked. **If you have questions, please call 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 Driver" Section.
- DMV Headquarters will verify the insurance information submitted. Complete the insurance section or DMV may suspend your driving privileges.

SECTION 1

DATE, LOCATION AND TIME — Clearly identify the date, location and time of the collision. The correct date, location and time are critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

SECTION 2

Your vehicle is Vehicle #1. Complete ALL fields. **Provide insurance company name (not agent), policy number, and vehicle identification number (VIN).** Failure to provide complete insurance and vehicle information may result in DMV issuing Notice of Suspension due to incomplete information.

SECTION 3

Failure to complete this section may result in DMV sending Notice of Suspension for failure to file a report. Principal purpose of driving and being paid to drive does not mean driving to reach 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 now file the Motor Carrier Collision Report 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. Only a family member may sign and date this form on behalf of a driver when the driver is incapacitated or physically unable to sign. No other signatures will be accepted.

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 CAN NOT 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 outlined in Section 3. Failure to report when required may result in DMV issuing Notice of Suspension. Call 503-945-5098 for assistance in 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"/> T <input type="radio"/> F <input type="radio"/> S <input type="radio"/> S N	TIME OF DAY <input type="radio"/> AM <input type="radio"/> PM	COUNTY	DMV USE ONLY			ALIR <input type="checkbox"/>	INS CO <input type="checkbox"/>
	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"/> More than two vehicles	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Paved vehicle	<input type="checkbox"/> Overturned vehicle	
	NAME OF NEAREST CITY / TOWN				<input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W	<input type="checkbox"/> Fatality	<input type="checkbox"/> Motor Home / RV	<input type="checkbox"/> Animal	<input type="checkbox"/> Fixed object / property	

Complete ALL fields. Failure to provide complete information may result in DMV issuing Notice of Suspension.

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	

POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	STATE	VEHICLE PLATE NUMBER	YEAR	MAKE & MODEL
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SECTION 3	Check all statements that apply:	<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.
		<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.	
	Name of police department: _____ <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State Police	
	<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 material.	
	<input type="checkbox"/> A citation was issued to you. The citation was: _____	

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	MAKE & MODEL

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	PHONE NUMBER OF DRIVER ()	

YOU INTENDED TO...	YOUR VEHICLE	WEATHER CONDITIONS	YOUR RESIDENCE
<input type="checkbox"/> Go straight ahead <input type="checkbox"/> Make right turn <input type="checkbox"/> Make left turn <input type="checkbox"/> Make "U" turn <input type="checkbox"/> Back up <input type="checkbox"/> Enter driveway (also mark left or right turn) <input type="checkbox"/> Remain stopped in traffic <input type="checkbox"/> Enter parked position <input type="checkbox"/> Slow or Stop <input type="checkbox"/> Leave driveway (also mark left or right turn) <input type="checkbox"/> Start in traffic lane <input type="checkbox"/> Leave parked position <input type="checkbox"/> Remain parked <input type="checkbox"/> Overtake and pass	<input type="checkbox"/> Passenger car, pickup, van <input type="checkbox"/> Military vehicle <input type="checkbox"/> Taxicab <input type="checkbox"/> Emergency vehicle <input type="checkbox"/> Any of the above and trailer <input type="checkbox"/> Priv. or public agency transit veh. <input type="checkbox"/> Bus <input type="checkbox"/> School bus <input type="checkbox"/> Other publicly-owned veh. <input type="checkbox"/> Motorcycle <input type="checkbox"/> Motor Home / RV <input type="checkbox"/> Motor scooter / bike <input type="checkbox"/> Personal (assisted) mobility device <input type="checkbox"/> Truck tractor & semi trailer <input type="checkbox"/> Truck/truck tractor <input type="checkbox"/> Other truck combination <input type="checkbox"/> Farm tractor/farm equip.	<input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Fog <input type="checkbox"/> Other ROAD SURFACE <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Snowy <input type="checkbox"/> Icy <input type="checkbox"/> Other LIGHT CONDITIONS <input type="checkbox"/> Daylight <input type="checkbox"/> Dawn or dusk <input type="checkbox"/> Darkness (lighted) <input type="checkbox"/> Darkness (unlighted) <input type="checkbox"/> Other	<input type="checkbox"/> Local resident (within 25 miles of collision site) <input type="checkbox"/> Residing elsewhere in state <input type="checkbox"/> Non-resident of this state: <input type="checkbox"/> College student <input type="checkbox"/> Military <input type="checkbox"/> Temporary job YOU WERE HEADED <input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West On: _____ (name of street, road or route) OTHER DRIVER WAS HEADED <input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West On: _____ (name of street, road or route)

WITNESS INFORMATION:

OCCUPANT INJURY AND SAFETY EQUIPMENT INFORMATION

SAFETY EQUIPMENT CODES

WRITE one of the codes (0-10) in column C

- 0 No seat belt available
 1 Seat belt available but NOT used
 2 Seat belt available and in use
 3 Child restraint device available but NOT used
 4 Child restraint device in use
 5 Child restraint device not available
 6 Helmet NOT in use
 7 Helmet in use
 8 Air bag deployed
 9 Air bag available - NOT deployed
 10 Air bag NOT available

INJURY CODE FOR OCCUPANTS

WRITE one of the codes (1-5) in column D

- 1 Fatal
 2 Suspected Serious: severe laceration, broken or distorted limb, crush injury, significant burns, unconsciousness, paralysis
 3 Suspected Minor: lump, abrasions, bruises, minor lacerations
 4 Possible
 5 No apparent

GENDER CODE

WRITE M, F or X in column A

SEAT POSITION	OCCUPANTS' NAMES (your vehicle)	A GENDER	B AGE	C SFTY EQP	D AIR BAG	D INJURY
DRIVER						
FRONT CENTER						
FRONT RIGHT						
MIDDLE* LEFT						
MIDDLE* CENTER						
MIDDLE* RIGHT						
REAR LEFT						
REAR CENTER						
REAR RIGHT						

* Use only for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

If this collision involved a pedestrian or bicyclist, complete the following:

☐ PEDESTRIAN NAME ☐ BICYCLIST NAME

Pedestrian or bicyclist was going:

☐ N ☐ S ☐ E ☐ W

ALONG OR ACROSS: (name of street, road or route)

From:

To:

EXAMPLE: (From: NE corner To: SE corner (or) From: East side To: West side, etc.)

Gender and age of pedestrian / bicyclist:

☐ M ☐ F ☐ X Age: _____

Extent of pedestrian / bicyclist injury:

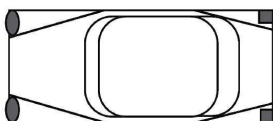
☐ Fatal ☐ Complaint of Pain
☐ Suspected Serious ☐ No apparent injury
☐ Visible injury (or none noted)

Pedestrian / bicyclist action: (mark one)

- ☐ Crossing at intersection or crosswalk
☐ Crossing **not** at intersection or crosswalk
☐ Walking / riding in roadway with traffic
☐ Walking / riding in roadway **against** traffic
☐ Standing in roadway
☐ Pushing or working on vehicles in roadway
☐ Other working in road
☐ Playing in road
☐ Hitchhiking
☐ Not in roadway
☐ Other _____
 (specify)

Vehicle Damage

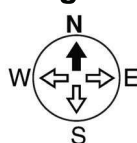
FRONT



USE ARROW TO SHOW
FIRST IMPACT (SHADE
IN DAMAGED AREA)

- ☐ Vehicle towed
☐ Rollover
☐ Under car
☐ Totaled
☐ Unknown

Diagram



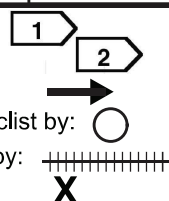
Number each vehicle:

Show path by:

Show pedestrian/bicyclist by:

Show railroad tracks by:

Show fixed object by:



— (name of street,
road or route) — ↑

— (name of street,
road or route) — ↑

← (name of street,
road or route)



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			VEHICLE PLATE NUMBER		STATE	YEAR	MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)			DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	GENDER OM OF OX
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			VEHICLE PLATE NUMBER		STATE	YEAR	MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)			DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	GENDER OM OF OX
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			VEHICLE PLATE NUMBER		STATE	YEAR	MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)			DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	GENDER OM OF OX
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			VEHICLE PLATE NUMBER		STATE	YEAR	MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)			DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	GENDER OM OF OX
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			VEHICLE PLATE NUMBER		STATE	YEAR	MAKE & MODEL
OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)			DRIVER'S LICENSE NUMBER		STATE	DATE OF BIRTH	GENDER OM OF OX
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 AND SUBMIT TO THE ADDRESS SHOWN ABOVE. **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		CRITERIA	
<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"/> ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE COLLISION)	
<input type="checkbox"/> HAZARDOUS MATERIAL PLACARD		<input type="checkbox"/> ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE	
<input type="checkbox"/> COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS)		<input type="checkbox"/> ANY VEHICLE INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE	
<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.)			
MOTOR CARRIER NAME		US DOT NUMBER	AUTHORITY/FILE NUMBER
ADDRESS		CITY	STATE ZIP CODE




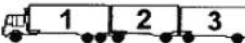
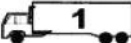

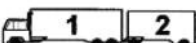


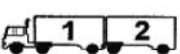

DRIVER INFORMATION	
DRIVER NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH
CDL / DL NUMBER	STATE
LICENSE CLASS	EXPIRATION DATE OF MEDICAL CERTIFICATE
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> M	

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	TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)
<input type="checkbox"/> YES <input type="checkbox"/> NO	

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

OTHER DRIVER INJURY INFORMATION			
TOTAL NUMBER OF OTHER DRIVERS	TOTAL NUMBER OF OTHER PASSENGERS	TOTAL NUMBER OF PEDESTRIANS	TOTAL NUMBER OF BICYCLISTS
____ KILLED ____ INJURED	____ KILLED ____ INJURED	____ KILLED ____ INJURED	____ KILLED ____ INJURED

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								
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 Toter☐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. SNOWY ☐ 4. ICY ☐ 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
<input type="checkbox"/>	SLOWING - STOPPING	<input type="checkbox"/>	PASSING	<input type="checkbox"/>	JACKKNIFE
<input type="checkbox"/>	STOPPED	<input type="checkbox"/>	CHANGING LANES	<input type="checkbox"/>	OVERTURN
<input type="checkbox"/>	REAR-END	<input type="checkbox"/>	SIDESWIPE	<input type="checkbox"/>	SEPARATION OF UNITS
<input type="checkbox"/>	BACKING	<input type="checkbox"/>	HEAD-ON	<input type="checkbox"/>	FIRE
<input type="checkbox"/>	MAKING RIGHT TURN	<input type="checkbox"/>	SKIDDING	<input type="checkbox"/>	EXPLOSION
<input type="checkbox"/>	MAKING LEFT TURN	<input type="checkbox"/>	VEHICLE OUT OF CONTROL	<input type="checkbox"/>	CARGO SHIFT
<input type="checkbox"/>	MAKING U TURN	<input type="checkbox"/>	ROLL-AWAY	<input type="checkbox"/>	CARGO SPILL (HAZARDOUS)
<input type="checkbox"/>	PROCEEDING STRAIGHT	<input type="checkbox"/>	CONTROLLED RR CROSSING	<input type="checkbox"/>	CARGO SPILL (NON-HAZARDOUS)
<input type="checkbox"/>	INTERSECTION	<input type="checkbox"/>	UNCONTROLLED RR CROSSING	<input type="checkbox"/>	OTHER (DEER, GUARDRAIL, ETC)
<input type="checkbox"/>	ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)	<input type="checkbox"/>	RAN OFF ROAD	<input type="checkbox"/>	_____

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 | I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE
X

DATE