PRELIMINARY REPORT OF ACCIDENT OR LOSS

(To Be Completed When Driver Calls to Report Accident or Loss)

Date of Accident ____________ Time ____________ ☐ A.M. ☐ P.M. Day of Week ____________

TOTAL NUMBER OF VEHICLES INVOLVED IN ACCIDENT? COMPANY ________ OTHERS ________

Company Driver ____________ Truck or Tractor No. ____________ Trailer No.(s) ____________

Have YOU been cited for a moving violation? ☐ Yes ☐ No

Can you be reached by phone, if necessary to call back? Phone No. ( ) ________ City ________ State ________

Accident Within City, Town or Village Limits	In ____________ (City, Town, Village) (County) (State) On ____________ (Street) At or Near ____________ (Cross Street)
Accident Outside City, Town or Village Limits	Accident Occurred on ____________ (Route Number and Road Name) Near ________ (Town) In ________ (County) At ____________ (Name intersection or state distance and direction from nearest community, highway junction, crossroad, milepost) Total Number of Lanes ________ (Both Directions) Were Lanes Marked? ☐ Yes ☐ No Were Opposing Lanes Separated by a Curb or Median? ☐ Yes ☐ No

TRAFFIC CONTROL AT SCENE

1. Signal Light ☐
2. Stop Sign ☐
3. Police Officer ☐
4. Warning Sign ☐
5. RR Lights/Gates ☐
6. RR Crossbuck ☐
7. Work Zone ☐
8. Other Control ☐
9. No Control ☐

Cause of Accident or Loss	Weather Condition ____________ Condition of Road ____________ Description of Accident: ____________
Driver of Other Vehicle	Name ____________ Make of Vehicle ____________ Address ____________ (Street or R.D.) (City & State) Model ____________ Operator's License No. ____________ (No.) (State) Registration ____________ (No.) (State)

Casualties? (indicate number)

	Fatalities	Injuries
Company Employee	______	______
Occupants other vehicles	______	______
Pedestrians	______	______

Have you called Police? ☐ Yes ☐ No

Have you called for medical assistance? ☐ Yes ☐ No

Where have injured persons been taken?

	Yes	No
Have you properly set emergency warning devices?	☐	☐
Have you secured witnesses - names & addresses?	☐	☐
Did accident involve fire or explosion?	☐	☐
Can your unit proceed safely under own power?	☐	☐
Did accident damage cause ANY vehicle to be towed?	☐	☐

REMARKS ____________

Hospital ____________ City/State ____________

Was unit transporting hazardous materials? ________ ☐ Hazardous substances ☐ Hazardous waste ☐ Marine pollutants

Give name(s) and class(es) of hazardous materials ____________

Was unit transporting oil subject to oil spill response plan? ____________

Were there any leaks or spills of the above materials? ____________

Is there any fuel leakage from your unit? ____________

Notes on instructions to Company Employee: *(Use other side of this form for additional information)*

Person Notified ____________ Time ________ ☐ A.M. ☐ P.M.

Date ____________ Signature ____________

SAMPLE

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