

# CHECKLIST FOR ACCIDENT INVESTIGATION – FORMS

COMPANY: \_\_\_\_\_ ACCIDENT REPORT NO.: \_\_\_\_\_

VEHICLE NO.: \_\_\_\_\_ VEHICLE DESCRIPTION: \_\_\_\_\_

DRIVER: \_\_\_\_\_ DRIVER ID. NO.: \_\_\_\_\_

DRIVER TELEPHONE: \_\_\_\_\_ ACCIDENT DATE: \_\_\_\_\_ ACCIDENT TIME: \_\_\_\_\_

ACCIDENT LOCATION: \_\_\_\_\_

HOME TERMINAL: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ FAX: \_\_\_\_\_

DRIVER STATUS (Check One):    \_\_\_ Permanent    \_\_\_ Union    \_\_\_ For Hire, union  
    \_\_\_ Temporary    \_\_\_ Non-union    \_\_\_ For Hire, non-union

**INSTRUCTIONS:** Identify each document required as part of this accident investigation by checking the "yes" or "no" boxes below. If "yes", record the date when each document has been correctly completed and returned to the accident investigation file. Items printed in red are specific for Department of Transportation regulatory compliance. Stock product forms are identified with the product code in parenthesis.

REQUIRED	DATE	DOCUMENT	REQUIRED	DATE	DOCUMENT
Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	_____ Accident Records – Contacts (804-FS-C4)	<input type="checkbox"/>	<input type="checkbox"/>	_____ Settlements – Physical Injury
<input type="checkbox"/>	<input type="checkbox"/>	_____ Accident Call Record (803-FS-C5)			1. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Driver's Report Kit (33-F)			2. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Driver's Report at Accident Scene (33-F-2)			3. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Witness Card(s) (33-F-3)	<input type="checkbox"/>	<input type="checkbox"/>	_____ Settlements – Personal Property
<input type="checkbox"/>	<input type="checkbox"/>	_____ Exoneration Card (33-F-5)			1. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Witness Statements (805-FS-C4)			2. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Accident Scene Pictures (806-F)			3. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Department of Transportation Hazardous Materials Incident Report (Form DOT F 5800.1) (530-F)	<input type="checkbox"/>	<input type="checkbox"/>	_____ Workers' Compensation
<input type="checkbox"/>	<input type="checkbox"/>	_____ FMCSA-Accident Register (10-B)			1. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Police Report	<input type="checkbox"/>	<input type="checkbox"/>	_____ Other Company Reports
<input type="checkbox"/>	<input type="checkbox"/>	_____ Insurance Company Report			1. _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Vehicle Damage/Repair Reports			2. _____
					3. _____

## REPORTS FOR DRIVER'S CONFIDENTIAL FILE

If the driver is required to comply with the U.S. Department of Transportation Federal Motor Carrier Safety Regulation Part 382.303 regarding post-accident testing for alcohol and controlled substances, complete the following testing dates and contacts:

- (1) Alcohol testing:                      Date: \_\_\_\_\_ Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_
- (2) Controlled substance testing:      Date: \_\_\_\_\_ Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

CHECKLIST COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_