

ACCIDENT CALL RECORD - INCOMING CALL -

ACCIDENT REPORT NUMBER

ACCIDENT DATA	DRIVER _____	DATE OF ACCIDENT _____	TIME _____
	PHONE NUMBER WHERE YOU CAN BE REACHED _____		
	LOCATION (Town, City, State) _____		
	ROADWAY (Route #, Street, Hwys.) _____		
	LANDMARK (Milepost, Building, etc.) _____		
	ARE YOU HAULING HAZARDOUS MATERIALS? _____	CLASSIFICATION? _____	
	DESCRIPTION OF ACCIDENT _____ _____		

DEATH & INJURY	HAS ANYONE BEEN KILLED? _____ (State Name) _____	
	INJURY? _____ (State Name & Extent of Injury) _____	
	WHERE TAKEN? _____	
	WAS THERE ANYONE ELSE IN YOUR VEHICLE AT THE TIME OF THE ACCIDENT? _____	
	(State Name & Reason) _____	

VEHICLES & CARGO	NUMBER OF VEHICLES INVOLVED? _____	DAMAGE TO YOUR VEHICLE? _____	DAMAGE TO _____
	OTHER VEHICLES? _____	EXTENT OF DAMAGE TO YOUR VEHICLE? _____	
	CAN YOU CONTINUE UNDER YOUR OWN POWER? _____		NEED WRECKER? _____
	ANY DAMAGE TO YOUR CARGO? _____		

ROADWAY	(Check Appropriate Boxes)			
	ACCIDENT OCCURRED ON:	NO. OF LANES:	VISIBILITY:	
	<input type="checkbox"/> Straightaway	<input type="checkbox"/> 2 - Lane	<input type="checkbox"/> Clear	<input type="checkbox"/> Snow
	<input type="checkbox"/> Hilltop	<input type="checkbox"/> 3 - Lane	<input type="checkbox"/> Rain	<input type="checkbox"/> Fog
	<input type="checkbox"/> Level	<input type="checkbox"/> 4 - Lane	<input type="checkbox"/> Sleet	Other _____
	<input type="checkbox"/> Curve	Other _____	ROAD SURFACE:	
<input type="checkbox"/> Exit Ramp	ROADWAY:	<input type="checkbox"/> Dry	<input type="checkbox"/> Concrete	
<input type="checkbox"/> Entrance Ramp	<input type="checkbox"/> Lighted	<input type="checkbox"/> Wet	<input type="checkbox"/> Blacktop	
TYPE OF ROADWAY:	<input type="checkbox"/> Unlighted	<input type="checkbox"/> Snowy	<input type="checkbox"/> Under Construction or Repair	
<input type="checkbox"/> Divided	<input type="checkbox"/> Marked	<input type="checkbox"/> Icy	Other _____	
<input type="checkbox"/> Undivided	<input type="checkbox"/> Unmarked			
<input type="checkbox"/> Limited Access				

REMINDE	<input type="checkbox"/> Complete Driver's Report	<input type="checkbox"/> Discuss Accident Only With Proper Authorities	<input type="checkbox"/> Alcohol Test: If required, at which location? _____
	<input type="checkbox"/> Set Warning Devices	<input type="checkbox"/> Protect Vehicle and Cargo	<input type="checkbox"/> Drug Test: If required, at which location? _____
	<input type="checkbox"/> Obtain Witnesses		

Person Dispatched to Scene _____ Title _____

Person Receiving Report _____ Title _____

(Date)

(Time)