



ACCIDENT KIT

****COMPLETE ACCIDENT REPORT****

1. STOP Your Vehicle Immediately
 1. Turn on Emergency Flasher
 2. Put Out Triangles and/or flares.
 3. Be sure at least one warning signal(triangle/flare) can be seen from all directions.

2. Check with other parties regarding their condition.
 1. Do not move anybody before medical help arrives. Cover the person to keep them warm.
 2. Use appropriate first aid only if you are trained to do so.
 3. If possible, do not move vehicles (do not admit any fault or apologize)

4. Notify
 1. Notify Your Safety Director/Dispatch
 2. Call Police
 3. Call the number(s) listed on your insurance card

4. Get License Plate Number of Other Vehicles
 1. Get name and phone numbers of other parties involved in accident

5. Use your Smart Phone to Take Pictures

6. Get Witness Information
 1. Secure and record any eyewitnesses.

7. Complete Accident Report
 1. Complete entire Accident Report. Please be as detailed as possible.

CDL DRIVERS

If an accident results in: A vehicle being towed, a person being transported by ambulance, or a Fatality, you must be tested for alcohol and drugs within two hours of the accident as required in section 382.303 of the Federal Motor Carrier Safety Regulations. Keep copies of the Federal Drug Testing and Control form in your vehicle at all times.

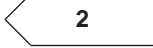


ACCIDENT SCENE


Instructions for Accident Diagram


Fill in dotted lines to correspond with road at accident site. Show position of all vehicles, pedestrians, etc., as follows:

Your vehicle  **1**

Other vehicle(s)  **2**

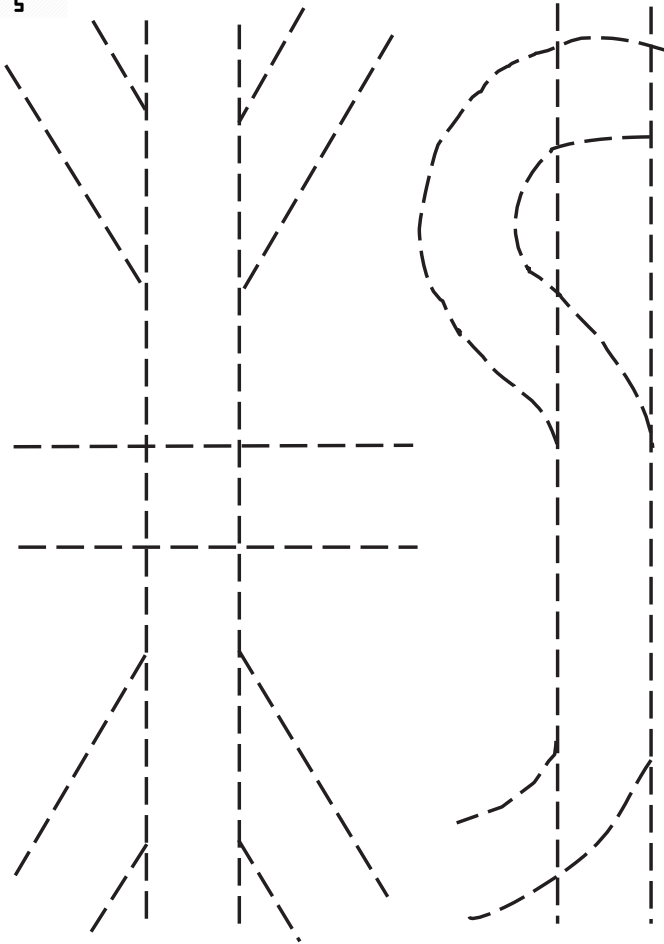
Numbered successively.

Pedestrian 

Traffic signal 

Traffic sign 

(indicate type)



Signature _____

Date _____

COMPANY NAME

DRIVER'S ACCIDENT REPORTING KIT

To Be Completed at Accident Scene

Driver's Name _____ Age _____

License No. _____

Phone No. _____

Vehicle Owner / Home Terminal _____

Equipment No. _____ Tractor: _____ TLR: _____

A. DATE, TIME, PLACE

Date _____: Time _____ AM; _____ PM _____

In _____
(City or Town) (County) (State)

On _____
(Street or Highway)

At _____
(Street Address or Intersection)

Distance and Direction from: _____
(Nearest community junction, etc.)

Open Country Business-Shopping

Residential Manufacturing-Industrial

Other (Describe) _____

B. WITNESSES

Persons seeing the accident will be of service to our driver by giving their names and addresses.

NAME _____

Address _____ Phone _____

NAME _____

Address _____ Phone _____

License number and descriptions of first vehicles at scene.

INVESTIGATING OFFICER

Name _____

Badge No. _____ Dept. _____

Citation: You _____ Other _____



C. THOSE INVOLVED

COMPANY VEHICLE (VEHICLE #1)

Make & _____
 Model _____
 Vin. _____ Fleet No. _____
 No. _____ No. _____
 Tag No. & State _____

OTHER VEHICLE (VEHICLE #2)

Make & _____
 Model _____
 Tag No. & State _____
 Driver _____
 Address _____
 Driver's License No. _____
 Name, address and phone of owner (if not the driver) _____

 Insurance Co. _____ Policy No. _____

OTHER VEHICLE (VEHICLE #3)

Make & _____
 Model _____
 Tag No. & State _____
 Driver _____
 Address _____
 Driver's License No. _____
 Name, address and phone of owner _____

 Insurance Co. _____ Policy No. _____

If other vehicles attach all information.

INJURED PERSONS

Number of persons injured _____ Killed _____
 Name _____ Age _____
 Address _____
 Injuries _____
 Where taken _____
 Name _____ Age _____
 Address _____
 Injuries _____
 Where taken _____
 Estimate of property damage \$ _____

D. TYPE OF ACCIDENT

Collision with Other Vehicle Collision with Fixed Object

	Veh. 1	Veh. 2	Veh. 3
<input type="checkbox"/> Ran off Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overturn in Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mechanical Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Loading or Unloading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Boarding / Alighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant fell out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupant injured inside vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

PEDESTRIAN ACTION

Crossing at Intersection Between Intersections
 With Signal Against Signal
 No Signal Diagonally
 Walking in Roadway Sidewalk No Sidewalk
 With Traffic Against Traffic
 Other (Describe): _____

E. VEHICLE MOVEMENT

	Veh. 1	Veh. 2	Veh. 3
Straight Ahead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slowing or Stopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stopped in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting in Traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting from Curb or Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U-Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skidding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overtaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrong Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowded off Road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evasive Action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			



F. VEHICLE CONDITION

MECHANICAL CONDITION

	Veh. 1	Veh. 2	Veh. 3
No Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tires / Wheels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Couplings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Windshield / Windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

G. ROADWAY CONDITIONS AND CONTROLS

- Not at Intersection
- Street Intersection
- Drive or Alley
- Crosswalk
- Other (describe) _____
- Not Divided
- Divided
- Limited Access
- No. of Lanes 2 3 4 6 _____
(Specify)

ROAD SURFACE

- Lanes Marked
- Concrete
- Blacktop
- Metal Grating (Bridge)
- Other (specify) _____
- No Defects
- Dry
- Wet
- Ice
- Snow
- Bridge / Overpass
- Underpass
- Private property
- Other off-street
- Unmarked
- Gravel
- Other Unpaved
- Mud
- Loose Material
- Cracks, holes, etc.
- Fresh Oil
- Under construction or repair _____
- Other (describe) _____
- Straight Level Hills Steep Moderate
- Curve R L Sharp Moderate

TRAFFIC CONTROLS

- Traffic Light
- Stop Sign
- Yield Sign
- Police Officer
- Were controls operating? Yes No
- RR Crossing Signal / Gate
- No Traffic Control
- Posted Speed Limit _____
- Other _____

WEATHER CONDITIONS

- Clear
- Snow
- Sleet
- Fog
- Rain
- Other (specify) _____
- Daylight
- Dawn
- Sunset
- Dark - road lighted
- Dark - road unlighted

H. PROPERTY DAMAGE

Point of Impact

	Veh. 1	Veh. 2	Veh. 3
Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Rear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Cargo Weight / Type: _____

Cargo Damage: _____

Other Property Damage: _____

I. MISCELLANEOUS INFORMATION

Time you reported for duty: _____

Total preceding hours off duty: _____

Hours since last sleep at time of going on duty: _____

Hours on duty at time of accident: _____

Total rest-stop time since going on duty: _____

Total other time, loading, etc.: _____

