

Auto Accident Checklist

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Fill out this report as completely as possible:

1. Police called? Yes ___ No ___

2. Other vehicle information:

Driver: _____

Name: _____

Address: _____

Phone: _____

Driver's License: _____

Relationship to registered owner: _____

Registration:

Name of registered owner: _____

Address: _____

License Plate: _____ Expiration Date: _____

Vehicle:

VIN: _____

Make: _____

Model: _____

Year: _____ Color: _____

Insurance Company: _____

Policy Number: _____

Phone: _____ Expiration Date: _____

Other passengers:

A. Name: _____

Age: _____ Male ___ Female ___

Address: _____

Phone: _____

B. Name: _____

Age: _____ Male ___ Female ___

Address: _____

Phone: _____

3. Accident Information

Police report taken? Yes ___ No ___

Report Number: _____

Officer Name: _____

Badge Number: _____

Time: _____ AM / PM Date: _____

Location of collision: _____

Direction of travel: _____

Your vehicle: _____

Other vehicle: _____

Injuries:

Your own: _____

Your passengers: _____

Other driver: _____

Their passengers: _____

Pedestrians: _____

Area of Damage:


Your vehicle: _____

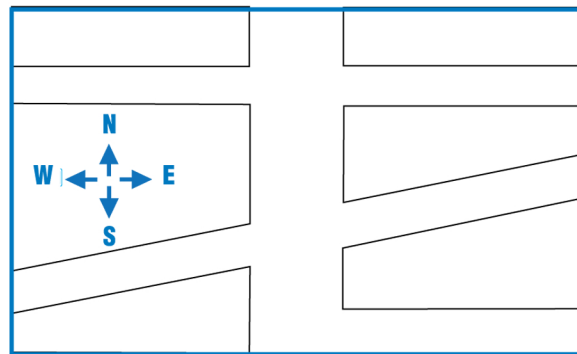
Other vehicle: _____

Other property: _____

Diagram of Accident Scene:

Using these symbols sketch a diagram showing positions of all vehicles, your position, stop lights, stop signs and pedestrians.

- 1 First Car
- 2 Second Car
- 3 Third Car
-  Your position
-  Pedestrian
-  Stop sign
-  Stop light
-  Witness



North/South Street: _____

East/West Street: _____