



When an Accident Happens:

1. Stop immediately, avoid obstructing traffic if possible.
2. Aid the injured.
3. Notify 911.
4. Obtain name and address of investigating police officer and badge number.
5. Obtain facts about damages to your vehicle.
6. Obtain facts about damages to other vehicle(s) and/or property damaged.
7. Get witness information.
8. Obtain facts about injured person(s).
9. Describe the accident on the accident report.
10. Never admit liability or agree to pay for damages.
11. Call your local insurance agent to report accident.
12. Do not discuss the accident except with police, or with your insurance company representative.

Accident Report:

#A – Damage to Your Vehicle

Name of Insured _____

Make of Car _____

Driver's Name _____

Driver's Address _____

Driver's Phone Number _____

Damage _____

Police Report? _____ Yes _____ No

Name or Police Dept. _____

If witness or witnesses are in another car and refuse to give their names, write down the license number.

License No. _____ License No. _____

#B – Damage to Property of Others

Owner _____ Phone (____) _____

Address _____

State Lic. _____ Make of Car _____ Year _____

Driver _____ Phone (____) _____

Address _____

Drivers License Number _____ Is car insured? _____

Insurance Company _____ Policy No. _____

Damage _____

#C – Damage to Property of Others

Owner _____ Phone (____) _____

Address _____

State Lic. _____ Make of Car _____ Year _____

Driver _____ Phone (____) _____

Address _____

Drivers License Number _____ Is car insured? _____

Insurance Company _____ Policy No. _____

Damage _____

Point of Impact – Check (X) for Each Vehicle

A	B	C		A	B	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lt. Side
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rt. Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lt. Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rt. Rear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rt. Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lt. Rear

Details of Accident

Date _____ Time _____

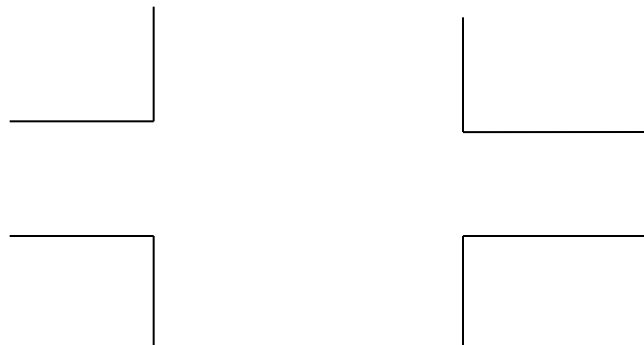
Place of Accident (name of streets) _____

Road Surface and condition _____

Weather conditions _____

	Our Car	Other Car
Going Which Direction		
Speed (Miles per Hour)		
Which Side of Street		
Distance from Curb		
Signals (Horn or Hand)		

Indicate point of collision and briefly describe what happened: _____



Witnesses

1. Name _____ Phone No (____) _____

Address _____

Where was witness? _____

2. Name _____ Phone No (____) _____

Address _____

Where was witness? _____

3. Name _____ Phone No (____) _____

Address _____

Where was witness? _____

Persons Injured

1. Name _____ Phone No (____) _____

Address _____

Nature of injuries _____

2. Name _____ Phone No (____) _____

Address _____

Nature of injuries _____

3. Name _____ Phone No (____) _____

Address _____

Nature of injuries _____