Vehicle Accident Report (Reporting Kit)

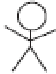
(Keep in vehicle glove box)
This form should be completed **in addition to** the Bay West Incident Investigation Report.
Bay West Insurance Carrier: Zurich American Insurance Company Policy #BAP568751800
Other Drivers should contact Zurich American at (800) 987-3373 with any questions.

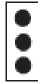
ACCIDENT SCENE
Instructions for Accident Diagram

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

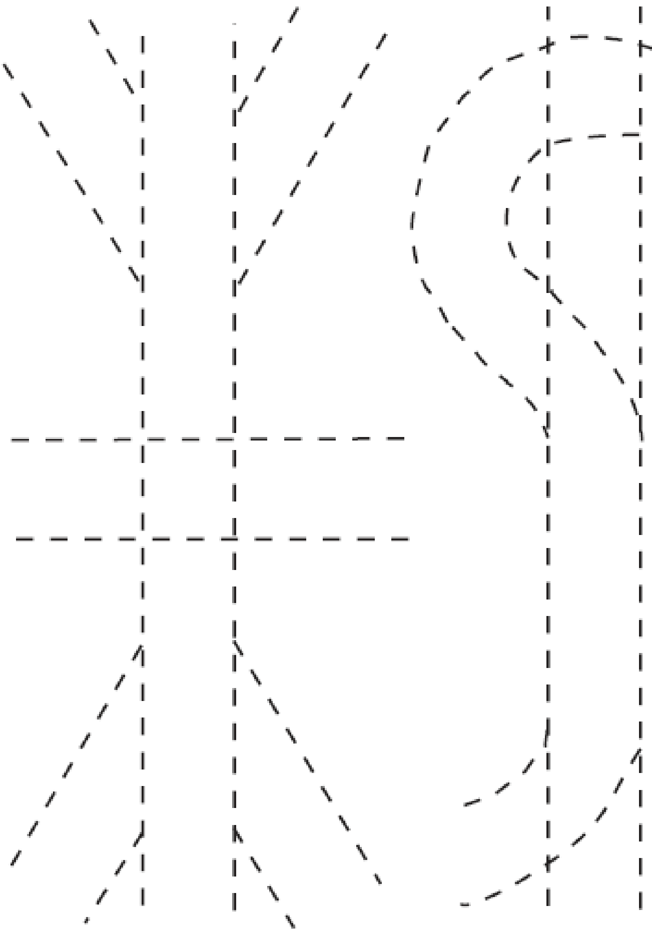
Your vehicle

Other vehicle(s) (numbered successively)

Pedestrian 

Traffic sign 

Traffic signal (indicate type)



Signature ____________________

Date ____________________

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 County
- ☐ 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 address.

Name ____________________

Address ____________________

Phone ____________________

Name ____________________

Address ____________________

Phone ____________________

License number and descriptions of first vehicle at scene

____

INVESTIGATING OFFICER

Name ____________________

Badge No. __________ Dept. __________

Citation: You __________ Other __________

C. THOSE INVOLVED

COMPANY VEHICLE (VEHICLE #1)

Make & Model ______________________________

VIN No. ____________________ Fleet 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 (if not the driver)

____

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
☐ Ran off Road	☐	☐	☐
☐ Overturn in Road	☐	☐	☐
☐ Mechanical Defect	☐	☐	☐
☐ Fire	☐	☐	☐
☐ Loading or Unloading	☐	☐	☐
☐ Boarding / Alighting	☐	☐	☐
☐ Occupant Fell Out	☐	☐	☐
☐ Occupant Injured Inside Vehicle	☐	☐	☐

☐ 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	☐	☐	☐
Turning Right	☐	☐	☐
Turning Left	☐	☐	☐
Slowing or Stopping	☐	☐	☐
Stopped in Traffic	☐	☐	☐
Starting in Traffic	☐	☐	☐
Starting from Curb or Shoulder	☐	☐	☐
Parked	☐	☐	☐
Backing Up	☐	☐	☐
U-Turn	☐	☐	☐
Skidding	☐	☐	☐
Overtaking	☐	☐	☐
Weaving	☐	☐	☐
Wrong Side	☐	☐	☐
Crowded Off Road	☐	☐	☐
Evasive Action	☐	☐	☐

☐ Other ______________________________

F. VEHICLE CONDITION

MECHANICAL CONDITION

	Veh. 1	Veh. 2	Veh. 3
No Defect	☐	☐	☐
Lights	☐	☐	☐
Brakes	☐	☐	☐
Tires / Wheels	☐	☐	☐
Engine	☐	☐	☐
Couplings	☐	☐	☐
Windshield / Windows	☐	☐	☐
Disabled	☐	☐	☐

Other ______________________________

G. ROADWAY CONDITIONS AND CONTROLS

☐ Not at Intersection
☐ Street Intersection
☐ Drive or Alley
☐ Crosswalk
☐ Bridge / Overpass
☐ Underpass
☐ Private Property
☐ Other Off-Street

☐ Other (describe) ______________________
☐ Not Divided ☐ Divided ☐ Limited Access
☐ Number of Lanes 2 3 4 6 ____________ (specify)

ROAD SURFACE

☐ Lanes Marked
☐ Concrete
☐ Blacktop
☐ Unmarked
☐ Gravel
☐ Other Unpaved
☐ Metal Grating (Bridge)
☐ Other (specify) ______________________
☐ No Defects
☐ Dry
☐ Wet
☐ Ice
☐ Snow
☐ Mud
☐ Loose Material
☐ Cracks, Holes, Etc.
☐ Fresh Oil
☐ Under Construction or Repair

☐ Other (describe) ______________________

☐ Straight ☐ Level ☐ Hills ☐ Steep ☐ Moderate
☐ Curve ☐ Right ☐ Left ☐ Sharp ☐ Moderate

TRAFFIC CONTROLS

☐ Traffic Light
☐ Stop Sign
☐ Yeild Sign
☐ Police Officer
☐ RR Crossing Signal / Gate
☐ No Traffic Control
☐ Posted Speed Limit ______
☐ Other ______________
Were Controls Operating? ☐ Yes ☐ No

WEATHER CONDITIONS

☐ Clear
☐ Snow
☐ Sleet
☐ Fog
☐ Rain
☐ Daylight
☐ Dawn
☐ Sunset
☐ Dark – Road Lighted
☐ Dark – Road Not Lighted

☐ Other (specify) ______________________

H. PROPERTY DAMAGE

POINT OF IMPACT

	Veh. 1	Veh. 2	Veh. 3
Front	☐	☐	☐
Rear	☐	☐	☐
Right Front	☐	☐	☐
Left Front	☐	☐	☐
Right Rear	☐	☐	☐
Left Rear	☐	☐	☐
Right Side	☐	☐	☐
Left Side	☐	☐	☐
Roof	☐	☐	☐

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. ______________________

Place of reporting on duty ______________________

Destination this trip ______________________

Miles traveled this trip until time of accident ____________

ICC Permits ______________________________

Trailer Owned by Others? ☐ Yes ☐ No

If yes, by whom ______________________________

Result of drug / alcohol tests ______________________

J. WHAT HAPPENDED?

At what distance did you first see danger? __________feet

How fast were you going? ____________________mph

What was your speed at impact? ________________mph

How far did your vehicle go after impact? __________feet

Describe in your own words the circumstances of the accident:

____

DESCRIBE DAMAGE TO

Your vehicle ______________________________

Other vehicles ______________________________

Cargo ______________________________

Property ______________________________

COMMENTS AND ADDITIONAL INFORMATION

____