

Driver's Accident Report Form

Take a photo of damage to both vehicles

Driver – Complete all items to the best of your ability (additional space on back), sign and date page 3 and give immediately to your supervisor

Supervisor – Sign page 4 and give form to Arc insurance point of contact

Arc Insurance POC – HR information contact; Workers Comp contact and scan/fax to Insurance Broker

Driver/Vehicle Information

Name of Driver (first and last)		Driver's Age	Driver License No.	State
Driver's Address – Street		City	State	Zip
		Telephone No. ()		
Name of Nonprofit / Employer				ANI/NIAC Policy Number
Nonprofit/Employer Contact Name		Contact Email Address		
Nonprofit / Employer Address – Street		City	State	Zip
		Telephone No. ()		
Make of Nonprofit's Vehicle	Body Type	Year	License Plate #	V.I.N. (last four digits)
Damage to Nonprofit's Vehicle:				

Accident Information

Date of Accident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Accident AM / PM	Location - Street or Highway & City	
On what street were you driving?			Direction (circle one) N S E W	Speed (approximate)
On what street was other vehicle driving?			Direction (circle one) N S E W	Speed (approximate)
Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of reporting officer	Agency	Citation/Report #	
Witness #1 Name (first and last)		Telephone No. ()	Email Address	
Witness #2 Name (first and last)		Telephone No. ()	Email Address	
Description of Accident (include weather and road conditions):				

(Use the back of this sheet if additional space is needed; please use the diagrams on page 3 to draw the accident)

Passenger(s) in Your Vehicle (attached additional pages if needed)

Name (first and last)	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ambulance called to scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of doctor or hospital			

Other Vehicle Involved

Name of Driver (first and last)		Driver License No.	State
Address - Street	City/State/Zip	Telephone No. ()	Email Address
Name of Vehicle Owner (if different than above)		Telephone No. ()	Email Address
Name of Insurance Company		Policy #	Telephone No. ()
Year/Make of Vehicle	Body Type	License Plate No.	State
Damage to Vehicle:			
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

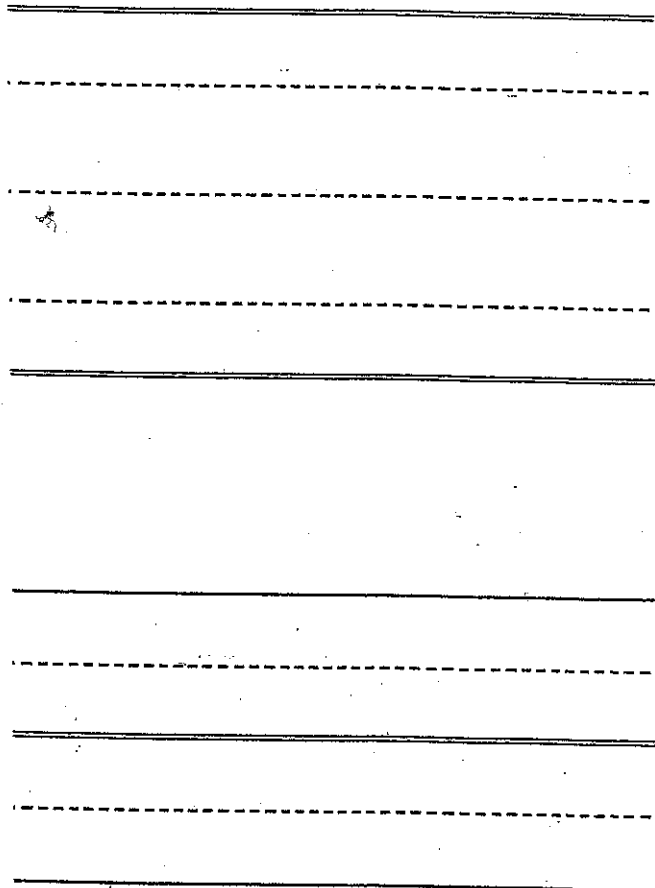
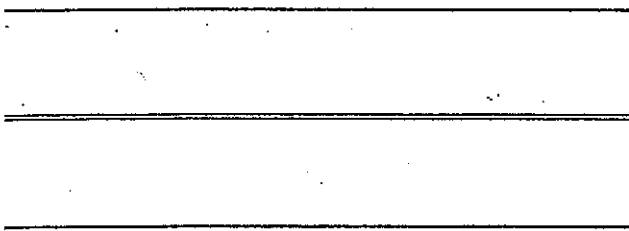
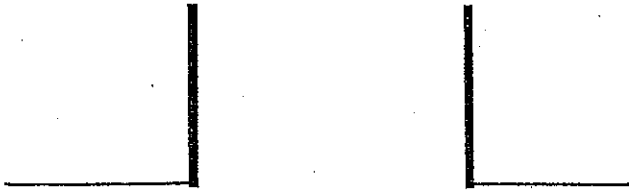
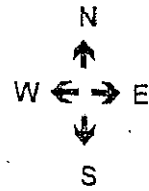
Other Vehicle Involved (if any)

Name of Driver (first and last)		Driver License No.	State
Address - Street	City/State/Zip	Telephone No. ()	Email Address
Name of Vehicle Owner (if different than above)		Telephone No. ()	Email Address
Name of Insurance Company		Policy #	Telephone No. ()
Year/Make of Vehicle	Body Type	License Plate No.	State
Damage to Vehicle:			
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

On the diagrams below, please draw the accident.
 (Be sure to include any stop signs or traffic signals.)

Legend:

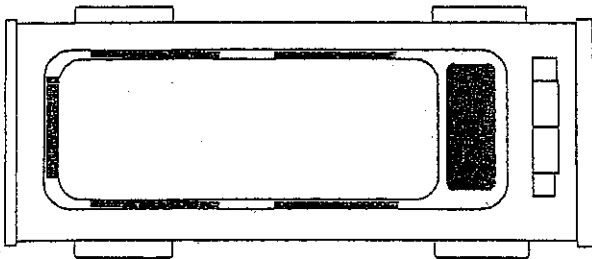
- V 1 ▶ Your Vehicle
- V 2 ▶ Other Vehicle
- V 3 ▶ Other Vehicle (if any)



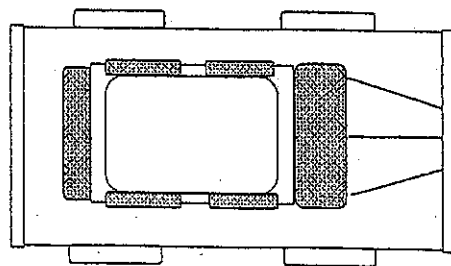
On the overhead diagrams below, please indicate the location of damage to *your* vehicle, if any.

ARC

back ----- VAN ----- front



back ----- AUTO ----- front



SIGNATURE OF DRIVER

DATE

To be completed by Supervisor/Program Director

Have you spoken with the driver to verify and/or clarify the information in this report?			
	Yes	No	
Have you seen the vehicle?	Yes	No	
Do the damages require repair:	Yes	No	In no, why not? _____ _____
Signature of Supervisor/Program Director		Date:	

TURN IN COMPLETED, SIGNED REPORT WITHIN 24 HOURS OF ACCIDENT

TO: Main Office

414