Names and Addresses of Persons Riding With You:

1. Name: _____
   Address: _____
   City: _____ State: _____ ZIP code: _____
2. Name: _____
   Address: _____
   City: _____ State: _____ ZIP code: _____
3. Name: _____
   Address: _____
   City: _____ State: _____ ZIP code: _____

Was the other driver alone?   ❑ Yes   ❑ No

Names of other persons with other driver:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____

Description of Accident: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Driver: _____

Driver's
Accident Report

A. Complete this form and submit to your employer immediately.

B. Carefully examine all damage.

C. Beware of "fake" investigators—(say nothing!—sign nothing!)

D. Do not talk to anyone about the accident except:
- your employer
- the investigation officer
- your insurance investigator

E. Do not argue with anyone at the scene of the accident. Show courtesy. Give your name and driver's license number as requested.

Note: In case of a serious accident, injury, or death, telephone your office at once!

Z RICH

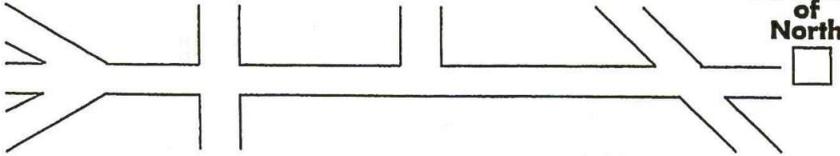**Direction of North** ☐

Indicate points of collision

Date:_____ Time:_____ Vehicle number:_____

Place of accident: _____

_____

Other driver's name: _____

Other driver's address:_____

City: _____ State:_____ ZIP code:_____

Other driver's license plate number: _____

Make of car: _____ Model: _____ Year:_____

Owner of other car: _____

Other driver's insurance company: _____

Damage to other vehicle: _____

_____

What direction were you going? _____

What direction was other car going? _____

Pavement: ☐ Dry   ☐ Wet   ☐ Ice/Snow

Weather: _____ Visibility: _____

Traffic control: ☐ Lights   ☐ Signs   ☐ None (indicate on diagram above)

Police investigation?   ☐ Yes   ☐ No

By who? (city, state, county) _____

Summons issued? _____ To whom? _____

Were you issued a state report to fill out? _____

_____

Complete this card for your employer and complete the state report if it is required.

Employee: _____

Injured Persons:

Name: _____ Age: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Extent of injuries: _____

_____

Name of hospital: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Damage to Property:

Owner: _____

Address: _____

City: _____ State: _____ ZIP code: _____

What was damaged? (other than other auto) _____

_____

Where is damaged property? _____

Witnesses: (This is important—get as many as possible)

1. Name: _____

   Address: _____

   City: _____ State:_____ ZIP code: _____

2. Name: _____

   Address: _____

   City: _____ State:_____ ZIP code: _____

3. Name: _____

   Address: _____

   City: _____ State:_____ ZIP code: _____

4. Name: _____

   Address: _____

   City: _____ State:_____ ZIP code: _____