



# DISTRICT OF COLUMBIA MOTOR VEHICLE ACCIDENT REPORT FORM

<b>CLAIM CODE/PHONE #</b>		<b>AGENCY CONTACT INFORMATION</b>		<b>AGENCY</b>	
DATE OF ACCIDENT	TIME OF ACCIDENT AM:  PM:	LOCATION ACCIDENT OCCURED: <input type="checkbox"/> NE <input type="checkbox"/> NW <input type="checkbox"/> SE <input type="checkbox"/> SW  _____ ft of _____ Street Street		STATE	
TYPE OF ACCIDENT (check one) __ 00 Collision of vehicles __ 01 Collision with fixed object __ 02 On board school bus __ 03 Boarding/Alighting __ 04 Pedestrian __ 05 Fatality	TRAFFIC CONDITIONS (check one) __ 00 Unknown __ 01 Heavy __ 02 Medium __ 03 Light	TRAFFIC CONTROLS (check one) __ 00 Unknown    __ 05 Flashing Light __ 01 Yield Sign    __ 06 Stop Sign __ 02 Signal    __ 07 None __ 03 Officer    __ 08 Other __ 04 Turn Restricted		ROAD SURFACE (check one) __ 00 Unknown __ 01 Concrete __ 02 Asphalt __ 03 Light __ 04 Gravel __ 05 Dirt __ 06 Other	ROAD CONDITION (check one) __ 01 Unknown __ 02 Repairing __ 03 Dry __ 04 Wet __ 05 Ice
ROAD TYPE (check one) __ 00 Straight    __ 05 Underpass __ 01 Curve    __ 06 Ramp __ 02 Level    __ 07 Bridge __ 03 Grade    __ 08 Divided __ 04 Crest	LIGHT CONDITIONS (check one) __ 00 Unknown __ 01 Dawn/Dusk __ 02 Dark __ 03 Daylight	STREET LIGHTS (check one) __ 00 Unknown __ 01 Defective street light(s) __ 02 No street light(s) __ 03 Street light(s) on __ 04 Street light(s) off		WEATHER (check ALL that apply) __ 00 Unknown    __ 03 Rain __ 01 Fog/Midst    __ 04 Snow __ 02 Clear    __ 05 Sleet	
Total # of Vehicles Involved: _____					
<b>District Driver &amp; Vehicle Information</b>					
District Vehicle No. _____		# of Passengers in District Vehicle: _____		# of Passengers Injured in District Vehicle: _____	
District Operator (Last Name, First Name, M.I.) _____		Age _____	Sex _____	Full or Part-time (FT or PT) _____	Driver Injured: Yes No
Drivers License # _____		License State: _____	Home Phone #: ( ) _____	Cell Phone #: ( ) _____	
Vehicle Model/Year _____	Make _____	Body Style _____	Tag #/State/Year _____	Vehicle Color _____	Vehicle Damaged: Yes or No
Speed at time of Impact: _____ mph		Skid Mark Details: _____			
Vehicle Driven Away: Yes or No Vehicle left at scene: _____			Yes or No If towed, to where: _____		
<b>VEHICLE TYPE</b> (check one) __ 00 Passenger Auto __ 01 Bus __ 02 Truck __ 03 Trailer __ 04 Other __ 05 Heavy Equipment	<b>PRIMARY CAUSE OF ACCIDENT:</b> Insert ONE code from below for <b>DISTRICT</b> vehicle here: <input type="checkbox"/> Insert ONE code from below for <b>CLAIMANT</b> vehicle here: <input type="checkbox"/>				
<b>DRIVER CONDITION</b> (check ALL that apply) __ 00 Fatigued __ 01 Ill __ 02 Physical defect __ 03 Asleep __ 04 Normal __ 05 Unknown __ 06 Ability Impaired __ 07 Ability not impaired	__ 00 Speed __ 01 Defective brakes __ 02 Signal __ 03 Auto right of way __ 04 Pedestrian right of way __ 05 Improper Turn __ 06 Yield Sign __ 07 Stop/Go light	__ 08 Flashing light __ 09 Directional light __ 10 Stop Sign __ 11 Alcohol influence __ 12 Improper passing __ 13 One way street-wrong way __ 14 Wrong side of street __ 15 Improper starting	__ 16 Other Defects __ 17 Pedestrian Violation __ 18 Driver inattention __ 19 Changing lanes no caution __ 20 Failure to set parking brake __ 21 Opened door in traffic __ 22 Drug influence __ 23 Improper Backing	__ 22 Defective light(s) __ 23 Pedestrian drunk __ 24 Road defects __ 25 Road defects __ 26 Driver vision obstructed __ 27 Other: _____	



DISTRICT OF COLUMBIA  
MOTOR VEHICLE ACCIDENT  
REPORT FORM

**Claimant Information**

Claimant (Last Name, First Name, M.I.) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Estimated Damage \$ \_\_\_\_\_

Home Address \_\_\_\_\_ Business Address \_\_\_\_\_

Drivers License #/State \_\_\_\_\_ Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Vehicle Model/Year: \_\_\_\_\_ Tag #/State/Year: \_\_\_\_\_  
Make: \_\_\_\_\_ Vehicle Color: \_\_\_\_\_  
Body Style: \_\_\_\_\_

Vehicle Damaged: Yes or No \_\_\_\_\_ Speed at time of Impact: \_\_\_\_\_ mph Skid Mark Details: \_\_\_\_\_  
Was vehicle driven away? Yes or No \_\_\_\_\_ Was vehicle left at the scene? Yes or No \_\_\_\_\_ If towed, to where: \_\_\_\_\_  
Tow Co. Info. \_\_\_\_\_

INJURY CODE (check ALL that apply) CLAIMANT CONDITION (check one)  
\_\_ 00 Fatal \_\_ 01 Disabling \_\_ 02 Non-disabling \_\_ 03 None \_\_ 00 Fatigued \_\_ 01 Ill \_\_ 02 Physical defect  
\_\_ 04 Unknown \_\_ 05 No visible injury \_\_ 06 complaint of pain/no visual injury \_\_ 03 Asleep \_\_ 04 Normal \_\_ 05 Unknown  
\_\_ 06 Ability Impaired \_\_ 07 Ability not impaired

TYPE OF VEHICLE (check one):  
\_\_ 00 Passenger Auto \_\_ 01 Bus \_\_ 02 Truck \_\_ 03 Trailer \_\_ 04 Unknown \_\_ 05 Taxi \_\_ 06 Motorcycle \_\_ 07 Bicycle  
\_\_ 08 Fire engine \_\_ 09 Ambulance \_\_ 10 Fixed Object \_\_ 11 Vendor Cart \_\_ 12 Other: \_\_\_\_\_

# of Passengers in Claimant Vehicle: \_\_\_\_\_ # of Passengers Injured in Claimant Vehicle: \_\_\_\_\_  
Do you have Collision Insurance? \_\_ Yes \_\_ No Amount of Deductible \$ \_\_\_\_\_

**Additional Claimant Information**

Claimant (Last Name, First Name, M.I.) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Estimated Damage \$ \_\_\_\_\_

Home Address \_\_\_\_\_ Business Address \_\_\_\_\_

Drivers License #/State \_\_\_\_\_ Home Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Vehicle Model/Year: \_\_\_\_\_ Tag #/State/Year: \_\_\_\_\_  
Make: \_\_\_\_\_ Vehicle Color: \_\_\_\_\_  
Body Style: \_\_\_\_\_

Vehicle Damaged: Yes or No \_\_\_\_\_ Speed at time of Impact: \_\_\_\_\_ mph Skid Mark Details: \_\_\_\_\_  
Was vehicle driven away? Yes or No \_\_\_\_\_ Was vehicle left at the scene? Yes or No \_\_\_\_\_ If towed, to where: \_\_\_\_\_  
Tow Co. Info. \_\_\_\_\_

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