

MOTOR VEHICLE ACCIDENT REPORT

DIVISION OF MOTOR VEHICLE SAFETY RESPONSIBILITY SECTION

DO NOT WRITE IN THIS SPACE
CASE NO. 1

LOCATION & TIME	MONTH	DAY	YEAR	DAY OF WEEK	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	MONDAY	TUESDAY	HOUR	MIN	TOTAL	TOTAL	TOTAL	TOTAL
	7	9	11	<input type="checkbox"/> SUNDAY	<input type="checkbox"/> WEDNESDAY	<input type="checkbox"/> THURSDAY	<input type="checkbox"/> FRIDAY	<input type="checkbox"/> SATURDAY	<input type="checkbox"/> SUNDAY	<input type="checkbox"/> MONDAY	<input type="checkbox"/> TUESDAY	13	15	17	18	19	20
													AM <input type="checkbox"/> 1	PM <input type="checkbox"/> 2	VEHICLES INVOLVED	INJURED INVOLVED	PEDESTRIANS INVOLVED
ACCIDENT OCCURRED ON (PRINT NAME OF STREET OR HIGHWAY) 21 <input type="text"/>													IF NOT AT AN INTERSECTION 23 HOW MANY FEET FROM NEAREST INTERSECTION <input type="text"/>				
ACCIDENT OCCURRED IN (NAME OF CITY OR TOWN) 41 <input type="text"/>													28 IN WHAT DIRECTION N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W <input type="checkbox"/> FROM 1 2 3 4				
IF AT INTERSECTION (NAME OF INTERSECTING STREET OR HIGHWAY) 60 <input type="text"/>													29 NAME NEAREST INTERSECTING STREET OR HIGHWAY <input type="text"/>				

ENVIRONMENTAL CONDITIONS	LIGHT CONDITION	WEATHER	ROAD SURFACE	ROAD CONDITION	TRAFFIC CONTROLS PRESENT
	1 <input type="checkbox"/> DAYLIGHT 46 2 <input type="checkbox"/> DAWN OR DUSK 3 <input type="checkbox"/> DARK - ROAD LIGHTED 4 <input type="checkbox"/> DARK - NOT LIGHTED	1 <input type="checkbox"/> CLEAR 47 2 <input type="checkbox"/> FOGGY 3 <input type="checkbox"/> CLOUDY 4 <input type="checkbox"/> RAINING 5 <input type="checkbox"/> SNOWING 6 <input type="checkbox"/> SLEETING	1 <input type="checkbox"/> DRY 48 2 <input type="checkbox"/> WET 3 <input type="checkbox"/> SNOWY 4 <input type="checkbox"/> ICE 5 <input type="checkbox"/> FRESH OIL 6 <input type="checkbox"/> OTHER	1 <input type="checkbox"/> NO DEFECTS 49 2 <input type="checkbox"/> HOLES, RUTS, BUMPS 3 <input type="checkbox"/> FOREIGN MATTER 4 <input type="checkbox"/> DEFECTIVE SHOULDER 5 <input type="checkbox"/> UNDER CONSTRUCTION 6 <input type="checkbox"/> OTHER	1 <input type="checkbox"/> STOP SIGN 2 <input type="checkbox"/> YIELD SIGN 3 <input type="checkbox"/> WARNING SIGN 4 <input type="checkbox"/> SIGNAL LIGHT 5 <input type="checkbox"/> FLASHING LIGHT 6 <input type="checkbox"/> R.R. CROSSING GATE

ACCIDENT CONDITIONS	ACCIDENT INVOLVED COLLISION WITH 1 <input type="checkbox"/> PEDESTRIAN 2 <input type="checkbox"/> PEDALCYCLE 3 <input type="checkbox"/> NO COLLISION - RAN OFF ROAD 4 <input type="checkbox"/> MOVING VEHICLE 5 <input type="checkbox"/> VEHICLE STOPPED IN ROAD 6 <input type="checkbox"/> PARKED MOTOR VEHICLE 7 <input type="checkbox"/> FIXED OBJECT 8 <input type="checkbox"/> OBJECT IN ROAD 9 <input type="checkbox"/> NO COLLISION - OVERTURNED 0 <input type="checkbox"/> OTHER	PEDESTRIAN ACTION 1 <input type="checkbox"/> ENTERING OR CROSSING ROAD 51 2 <input type="checkbox"/> MOVING WITH TRAFFIC 3 <input type="checkbox"/> MOVING AGAINST TRAFFIC 4 <input type="checkbox"/> STANDING IN ROAD 5 <input type="checkbox"/> GETTING ON/OFF VEHICLE 6 <input type="checkbox"/> PUSHING OR WORKING ON VEHICLE 7 <input type="checkbox"/> PLAYING IN ROADWAY 8 <input type="checkbox"/> WORKING IN ROADWAY 9 <input type="checkbox"/> HITCHHIKING 0 <input type="checkbox"/> OTHER	COLLISION TYPE 1 <input type="checkbox"/> SIDESWIPE - OPPOSITE DIRECTION 53 2 <input type="checkbox"/> SIDESWIPE - SAME DIRECTION 3 <input type="checkbox"/> HEAD-ON 4 <input type="checkbox"/> BROADSIDE 5 <input type="checkbox"/> ANGLE 6 <input type="checkbox"/> REAR END 7 <input type="checkbox"/> OTHER 8 <input type="checkbox"/> HIT AND RUN
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PROP. DAMAGE	DESCRIBE NON-VEHICLE PROPERTY DAMAGE NAME AND ADDRESS OF PROPERTY OWNER	DAMAGED BY VEHICLE NO. 56 <input type="text"/>	APPROXIMATE COST TO REPAIR 57 80 <input type="text"/>
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YOUR VEHICLE VEHICLE NO. 1	OPERATOR'S NAME (FIRST, MIDDLE INITIAL, LAST)	7 DATE OF BIRTH MO. / DAY / YEAR	9 SEX <input type="checkbox"/> M 1 <input type="checkbox"/> F 2	10 OPERATOR'S LICENSE NUMBER	21 STATE	23 DIRECTION OF TRAVEL N <input type="checkbox"/> 1 S <input type="checkbox"/> 2 E <input type="checkbox"/> 3 W <input type="checkbox"/> 4
	RESIDENCE ADDRESS (NO. AND STREET, CITY OR TOWN, AND STATE/ZIP)				32 STATE	
	VEHICLE OWNER (COMPLETE NAME AND ADDRESS)				34 VEHICLE IDENTIFICATION NUMBER (VIN)	
	57 VEHICLE MAKE		66 MODEL	73 YEAR	REGISTRATION CLASSIFICATION 75 (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	

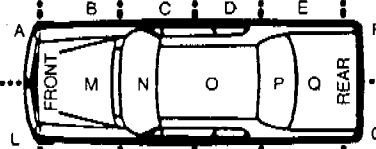
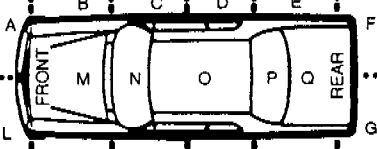
OTHER VEHICLE	OPERATOR'S NAME (FIRST, MIDDLE INITIAL, LAST)	7 DATE OF BIRTH MO. / DAY / YEAR	9 SEX <input type="checkbox"/> M 1 <input type="checkbox"/> F 2	10 OPERATOR'S LICENSE NUMBER	21 STATE	23 DIRECTION OF TRAVEL N <input type="checkbox"/> 1 S <input type="checkbox"/> 2 E <input type="checkbox"/> 3 W <input type="checkbox"/> 4	
	RESIDENCE ADDRESS (NO. AND STREET, CITY OR TOWN, AND STATE/ZIP)				32 STATE		
	VEHICLE OWNER (COMPLETE NAME AND ADDRESS)				34 VEHICLE IDENTIFICATION NUMBER (VIN)		
	(CITY OR TOWN, AND STATE/ZIP)		57 VEHICLE MAKE	66 MODEL	73 YEAR	REGISTRATION CLASSIFICATION 75 (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	



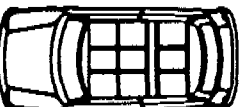
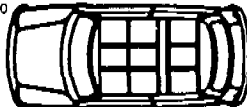
ACCIDENT INFORMATION	IF FIXED OBJECT, OBJECT COLLIDED WITH 01 <input type="checkbox"/> MEDIAN BARRIER 02 <input type="checkbox"/> GUARD RAIL 03 <input type="checkbox"/> CURBING 04 <input type="checkbox"/> ABUTMENT 05 <input type="checkbox"/> SIGNPOST 06 <input type="checkbox"/> UTILITY OR LIGHT POLE 07 <input type="checkbox"/> TREE 08 <input type="checkbox"/> EMBANKMENT 09 <input type="checkbox"/> DITCH 10 <input type="checkbox"/> ROCK OR LEDGE 11 <input type="checkbox"/> STONE WALL OR FENCE 12 <input type="checkbox"/> BRIDGE RAIL 13 <input type="checkbox"/> CONSTRUCTION BARRIER 14 <input type="checkbox"/> OTHER FIXED OBJECT	7	DESTINATION OF YOUR TRIP PRIOR TO ACCIDENT 1 <input type="checkbox"/> HOME 2 <input type="checkbox"/> WORK 3 <input type="checkbox"/> SHOPPING 4 <input type="checkbox"/> SCHOOL 5 <input type="checkbox"/> RECREATION 6 <input type="checkbox"/> SOCIAL 7 <input type="checkbox"/> BUSINESS 8 <input type="checkbox"/> OTHER	9	YOUR VEHICLE MILEAGE READING 11 <input type="text"/>
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ACCIDENT INFORMATION	WHAT WAS YOUR VEHICLE DOING PRIOR TO ACCIDENT? 01 <input type="checkbox"/> MAKING RIGHT TURN 02 <input type="checkbox"/> MAKING LEFT TURN 03 <input type="checkbox"/> MAKING U-TURN 04 <input type="checkbox"/> STRAIGHT AHEAD 05 <input type="checkbox"/> PASSING ON RIGHT 06 <input type="checkbox"/> PASSING ON LEFT 07 <input type="checkbox"/> STOPPED AT STOP SIGN 08 <input type="checkbox"/> SKIDDING 09 <input type="checkbox"/> SLOWING/STOPPING 10 <input type="checkbox"/> CROSSING MEDIAN 11 <input type="checkbox"/> MOVING VEH. - NO DRIVER 12 <input type="checkbox"/> BACKING 13 <input type="checkbox"/> STARTING IN TRAFFIC 14 <input type="checkbox"/> STARTING FROM PARK	15 <input type="checkbox"/> PARKED 16 <input type="checkbox"/> PARKING 17 <input type="checkbox"/> STALLED/DISABLED 18 <input type="checkbox"/> STALLED/DISABLED WITH FLASHERS ON 19 <input type="checkbox"/> ENTERING/EXITING FROM DRIVEWAY 20 <input type="checkbox"/> OTHER	16	VEHICLE FAILURE 1 <input type="checkbox"/> BRAKE FAILURE 2 <input type="checkbox"/> LIGHT FAILURE 3 <input type="checkbox"/> STEERING FAILURE 4 <input type="checkbox"/> TIRE FAILURE 5 <input type="checkbox"/> NO FAILURES 6 <input type="checkbox"/> OTHER	18	VISUAL OBSTRUCTIONS 1 <input type="checkbox"/> TREES, SHRUBS, CROPS 2 <input type="checkbox"/> BUILDING 3 <input type="checkbox"/> EMBANKMENT 4 <input type="checkbox"/> SIGN OR BILLBOARD 5 <input type="checkbox"/> PARKED VEHICLE 6 <input type="checkbox"/> VISION NOT BLOCKED 7 <input type="checkbox"/> OTHER	19
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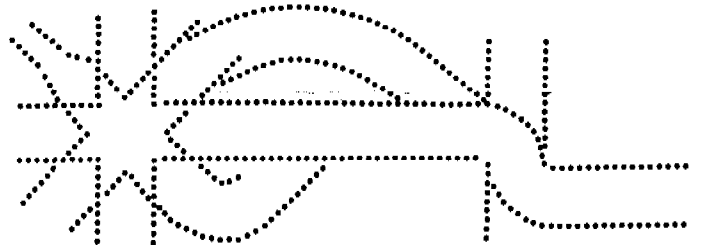





INSURANCE INFORMATION	WAS AUTO LIABILITY INSURANCE IN EFFECT ON THE DATE OF THE ACCIDENT? IF "YES" COMPLETE ATTACHED FORM YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME OF INSURANCE COMPANY: (NOT AGENT) NAME OF POLICYHOLDER:	POLICY NUMBER: STREET ADDRESS: CITY OR TOWN	POLICY EFFECTIVE DATE: FROM _____ TO _____ STATE/ZIP
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-COMPLETE BOTH SIDES OF THIS REPORT-

VEHICLE DAMAGE	APPROXIMATE COST TO REPAIR VEHICLE 1 20	FOR EACH VEHICLE INVOLVED, CIRCLE ON THE DIAGRAM THE LETTER OR LETTERS INDICATING THE DAMAGED AREA	APPROXIMATE COST TO REPAIR VEHICLE 2
	VEHICLE NO. 1 DAMAGE 24	USE THIS SPACE TO SKETCH DAMAGE TO TRAILERS OR MOTORCYCLES	VEHICLE NO. 2 DAMAGE
		<p style="font-size: small;">IF TRAILER IN TOW, SHOW REGISTRATION AND STATE</p> <p style="font-size: x-small;">34 _____ 40 (STATE) _____ TOWED BY _____ 42 _____</p> <p style="font-size: x-small;">VEHICLE NO. _____</p>	
R = UNDERCARRIAGE S = ROLLOVER T = TOTALED		R = UNDERCARRIAGE S = ROLLOVER T = TOTALED	

OCCUPANT INFORMATION	FOR YOUR VEHICLE PROVIDE THE FOLLOWING SEAT BELT INFORMATION			
	OCCUPIED SEATS	EJECTION	SEAT BELT USE	SEAT BELT TYPE
	INDICATE THE SEATS OCCUPIED FOR SIX-PASSENGER AUTOS USE 1 - 6 FOR NINE-PASSENGER WAGONS OR VANS USE 1-9 FOR BUCKET SEATS IN FRONT USE 1 AND 3 FOR BUCKET SEATS IN REAR USE 4 AND 6 FOR MOTORCYCLES USE 1 AND 4	FOR EACH OCCUPIED SEAT INDICATE WHETHER THE OCCUPANT WAS THROWN FROM THE VEHICLE BY PLACING THE PROPER CODE IN THE PROPER SEAT LOCATION 1 - NOT THROWN 2 - PARTIALLY THROWN 3 - TOTALLY THROWN 4 - UNKNOWN	FOR EACH OCCUPIED SEAT, ENTER THE SEAT BELT USE CODE IN THE PROPER SEAT LOCATION FOR MOTORCYCLES 1 - BELTS USED 6 - HELMETS USED 2 - BELTS NOT USED 7 - HELMETS NOT USED 3 - BELTS NOT INSTALLED 4 - BELTS FAILED 8 - USE UNKNOWN 5 - USE UNKNOWN	FOR EACH OCCUPIED SEAT, ENTER THE SEAT BELT TYPE CODE IN THE PROPER SEAT LOCATION 1 - LAP BELT 2 - SHOULDER HARNESS 3 - LAP/SHOULDER COMBINATION 4 - CHILD RESTRAINT 5 - OTHER
				

NAME OF INJURED: (FIRST, MIDDLE INITIAL, LAST)	STREET ADDRESS:	CITY OR TOWN:	STATE/ZIP:	INJURED WAS RIDING IN VEHICLE NO. x7
AGE x0 <input type="text"/>	WAS INJURED A CHILD IN LAP OF ADULT? YES <input type="checkbox"/> NO <input type="checkbox"/>	ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT x4 1 <input type="checkbox"/> FATAL 2 <input type="checkbox"/> BLEEDING OR BROKEN BONES 3 <input type="checkbox"/> BRUISES OR ABRASIONS 4 <input type="checkbox"/> COMPLAINT OF PAIN	PERSON INJURED x6 1 <input type="checkbox"/> PEDESTRIAN 5 <input type="checkbox"/> VEHICLE OPERATOR 2 <input type="checkbox"/> PEDALCYCLIST 6 <input type="checkbox"/> VEHICLE PASSENGER 3 <input type="checkbox"/> PASS IN BUS 7 <input type="checkbox"/> MOTORCYCLE OPER 4 <input type="checkbox"/> OTHER 8 <input type="checkbox"/> MOTORCYCLE PASS	SHOW SEAT OCCUPIED BY INJURED 
NAME OF INJURED: (FIRST, MIDDLE INITIAL, LAST)	STREET ADDRESS:	CITY OR TOWN:	STATE/ZIP:	INJURED WAS RIDING IN VEHICLE NO. x7
AGE x0 <input type="text"/>	WAS INJURED A CHILD IN LAP OF ADULT? YES <input type="checkbox"/> NO <input type="checkbox"/>	ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT x4 1 <input type="checkbox"/> FATAL 2 <input type="checkbox"/> BLEEDING OR BROKEN BONES 3 <input type="checkbox"/> BRUISES OR ABRASIONS 4 <input type="checkbox"/> COMPLAINT OF PAIN	PERSON INJURED x6 1 <input type="checkbox"/> PEDESTRIAN 5 <input type="checkbox"/> VEHICLE OPERATOR 2 <input type="checkbox"/> PEDALCYCLIST 6 <input type="checkbox"/> VEHICLE PASSENGER 3 <input type="checkbox"/> PASS IN BUS 7 <input type="checkbox"/> MOTORCYCLE OPER 4 <input type="checkbox"/> OTHER 8 <input type="checkbox"/> MOTORCYCLE PASS	SHOW SEAT OCCUPIED BY INJURED 

COLLISION DIAGRAM		INDICATE ON THIS DIAGRAM WHAT HAPPENED: USE ONE OF THE OUTLINES TO DESCRIBE THE SCENE OF THE ACCIDENT SHOWING STREET NAME AND HIGHWAY NUMBERS 1 NUMBER EACH VEHICLE AND SHOW DIRECTION OF TRAVEL BY ARROW  2 USE SOLID LINES FOR BEFORE ACCIDENT AND BROKEN LINES FOR AFTER 3 SHOW PEDESTRIAN BY  4 SHOW RAILROAD BY  5 SHOW DISTANCE AND DIRECTION TO LANDMARKS OR OTHER IDENTIFYING FEATURES 6 SHOW NORTH BY ARROW   INDICATE NORTH BY ARROW
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DESCRIBE WHAT HAPPENED -- REFER TO VEHICLES BY NUMBER:		FOR OFFICIAL USE ONLY: EDIT BY: _____ DATE: _____
BOTH SIDES OF THIS REPORT MUST BE COMPLETED	OPERATOR'S SIGNATURE: (THIS REPORT MUST BE SIGNED) X	DATE: _____

Instructions for completing report:

1. Print all information except signatures.
2. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
3. When multiple choices are provided, select the best choice.
4. Refer to your vehicle as vehicle #1, other vehicle as #2, #3, and so forth.
5. If more than two (2) vehicles were involved, more than two (2) persons were injured, or property belonging to more than one (1) person was damaged, use another report completing the appropriate sections.
6. Sign each report. Then seal report(s) in an envelope and mail to R.I. D.M.V. Safety Responsibility Section.
7. Complete location information as shown in example below. Print one letter per box; leave a blank between each word. Do not use periods or commas.

AT INTERSECTION

21 ACCIDENT OCCURRED ON (PRINT NAME OF STREET OR HIGHWAY) PARK AVE	IF NOT AT AN INTERSECTION
41 ACCIDENT OCCURRED IN (NAME OF CITY OR TOWN) CRANSTON	23 HOW MANY FEET FROM NEAREST INTERSECTION IN WHAT DIRECTION N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W <input type="checkbox"/> FROM
60 IF AT INTERSECTION (NAME OF INTERSECTING STREET OR HIGHWAY) WELLINGTON AVE	29 NAME NEAREST INTERSECTING STREET OR HIGHWAY

NOT AT INTERSECTION

21 ACCIDENT OCCURRED ON (PRINT NAME OF STREET OR HIGHWAY) MAIN AVE	IF NOT AT AN INTERSECTION
41 ACCIDENT OCCURRED IN (NAME OF CITY OR TOWN) PROVIDENCE	23 HOW MANY FEET FROM NEAREST INTERSECTION 125 28 IN WHAT DIRECTION N <input type="checkbox"/> S <input type="checkbox"/> E <input checked="" type="checkbox"/> W <input type="checkbox"/> FROM
60 IF AT INTERSECTION (NAME OF INTERSECTING STREET OR HIGHWAY)	29 NAME NEAREST INTERSECTING STREET OR HIGHWAY DUNCAN AVE

FOR USE BY INSURANCE COMPANY ONLY

RETURN THIS FORM ONLY IF NO STANDARD POLICY WAS IN EFFECT AS ALLEGED BY MOTORIST.

With regard to an automobile liability insurance policy for the policyholder named on the reverse side hereof, the undersigned insurance company advised you in accordance with the items checked below:

- 1. No policy was in effect on the date of the accident.
- 2. Our policy for the named policyholder applies to him as the operator but it does not apply to the owner of the vehicle involved in the accident
- 3. Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident.
- 4. Our policy affords bodily injury coverage only.
- 5. Our policy affords property damage coverage only.

To: STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS
 DIVISION OF MOTOR VEHICLES
 286 MAIN STREET
 PAWTUCKET, RI 02860

Remarks:

NAME OF INSURANCE COMPANY

By AUTHORIZED REPRESENTATIVE

Date _____

**RHODE ISLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ACCIDENT REPORT**

Under Rhode Island Law:

1. This report must be filed with the Division of Motor Vehicles by the vehicle operator (or by the vehicle owner if operator is physically incapable) within twenty-one (21) days of the date of any motor vehicle accident resulting in death, personal injury, or damage to the property of any one (1) person in excess of one thousand dollars (\$1,000). Failure to file as required may result in criminal prosecution and/or suspension of the operator's license.
2. This report is confidential and may not be used as evidence in civil or criminal courts; it is made without prejudice to the person reporting. This report is not available as public information, it may be used in Division of Motor Vehicles enforcement of the Safety Responsibility Act. Some information is extracted (names and dates) and made available to insurance companies for use in establishing individual rates.
3. False statements made on this report are illegal and punishable by a one thousand dollar (\$1,000.00) maximum fine and/or one (1) year maximum imprisonment.

RETURN TO: STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DIVISION OF MOTOR VEHICLES
286 MAIN STREET
PAWTUCKET, RI 02860

**READ
INSTRUCTIONS**

**COMPLETE
ALL SECTIONS**

Incomplete Forms Will Be Returned To Sender

RHODE ISLAND MOTOR VEHICLE ACCIDENT INFORMATION				DO NOT WRITE IN THIS SPACE CASE NO.
Date of Accident:		Place of Accident:		
DESCRIPTION OF VEHICLE INVOLVED IN ACCIDENT MUST CORRESPOND TO VEHICLE 1 ON ACCIDENT REPORT				
Vehicle Make:	Type:	Year:	Vehicle Identification Number:	
Name of Operator:	Street Address:	City or Town:	State/Zip:	
Name of Owner:	Street Address:	City or Town:	State/Zip:	
Name of Insurance Company (Not Agent):	Policy Number:	Effective Period:		
Name of Policyholder:	Street Address:	City or Town:	State/Zip:	
Name of Insurance Agent Who Issued Policy:	Street Address:	City or Town:	State/Zip:	
Your Signature: X			Date Signed:	
<p align="right">This Accident Should Be Reported Directly to Your Insurance Agent. Failure to Report May Jeopardize Your Auto Liability Insurance.</p>				