

WISCONSIN DRIVER REPORT OF ACCIDENT

(See instructions on reverse side before completing - Please Print)

**CONTINUE ONLY ...if there was \$1000 or more damage to any one person's property,
OR ...if anyone was injured,
OR ...if there was \$200 or more damage to government property, other than vehicles.**

<input type="checkbox"/> Hit & Run Accident?	<input type="checkbox"/> Hit a Deer?	ACCIDENT LOCATION	County of _____	City, Village or Township of _____	ACCIDENT DATE	Month _____	Day _____	Year _____	Day of Week _____	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	
<input type="checkbox"/> YES	<input type="checkbox"/> YES		Name and Number of Street(s) or Highway or Parking Lot _____								
Total Units Involved _____		Total Injured* _____									

<p>UNIT 1</p> <p>Driver Full Name (Last, First, MI) _____ Sex _____</p> <p>Address _____ Birth Date _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>Driver License Number _____ Issuing State _____</p> <p>Vehicle Legally Parked <input type="checkbox"/> YES <input type="checkbox"/> NO Operating a commercial vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, circle appropriate classification A B C</p> <p>Owner Full Name (Last, First, MI) _____</p> <p>Address _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>License Plate Number _____ Exp Yr _____ Issuing State _____ Vehicle Make _____ Year _____ Color _____</p> <p>Vehicle Identification Number _____</p> <p>Was a motor vehicle liability insurance policy in effect on the day of the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES Policy Holder's Name _____</p> <p>Exact Name of Insurance Company _____</p>	<p>UNIT 2</p> <p>Driver Full Name (Last, First, MI) _____ Sex _____</p> <p>Address _____ Birth Date _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>Driver License Number _____ Issuing State _____</p> <p>Vehicle Legally Parked <input type="checkbox"/> YES <input type="checkbox"/> NO Operating a commercial vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, circle appropriate classification A B C</p> <p>Owner Full Name (Last, First, MI) _____</p> <p>Address _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>License Plate Number _____ Exp Yr _____ Issuing State _____ Vehicle Make _____ Year _____ Color _____</p> <p>Vehicle Identification Number _____</p> <p>Was a motor vehicle liability insurance policy in effect on the day of the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES Policy Holder's Name _____</p> <p>Exact Name of Insurance Company _____</p>
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*** INJURED** Important Number of injuries reported must equal number entered in "Total Injured" box above. **Injury Codes: A=Severe, B=Moderate, C=Minor**

Unit No.	Name (Last, First, MI)	Address	City & State	Zip Code	Sex	Date of Birth	Injury Code

<p>VEHICLE Unit 1 - Important - Circle the numbers closest to the damaged areas.</p> <p>DAMAGE Damage Estimate (Required)</p> <p>\$ _____</p>	<p>Unit 2 - Important - Circle the numbers closest to the damaged areas.</p> <p>DAMAGE Damage Estimate (If Known)</p> <p>\$ _____</p>
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PROPERTY DAMAGE Describe what was damaged. Property damage includes structures, trees, fences, towed items, etc. Do NOT include vehicle damage.

Property Owner Full Name (Last, First, MI) _____	Address, City, State & Zip Code _____	Daytime Phone Number () _____
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<p>NARRATIVE Print a brief description of the accident.</p> <p> </p> <p> </p> <p> </p>	<p>DIAGRAM Draw a basic picture of the accident and location. Indicate North by putting an arrow in the circle.</p> <p style="text-align: right;">○</p> <p style="text-align: center; font-size: 2em; font-weight: bold;">X</p> <p style="text-align: right;">(Signature)</p>
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