



# REPORT OF TRAFFIC ACCIDENT OCCURRING IN CALIFORNIA

DMV USE ONLY

**READ IMPORTANT INFORMATION ON BACK**

AS APPROPRIATE, PLEASE TYPE OR PRINT IN BOXES

# OF VEHICLES	DATE OF ACCIDENT MMDDYY	CALIFORNIA COUNTY OF ACCIDENT	CALIFORNIA CITY WHERE ACCIDENT OCCURRED
TIME OF ACCIDENT Hour _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> In Traffic <input type="checkbox"/> Parked <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicyclist <input type="checkbox"/> Other (EXPLAIN, E.G., ROLLAWAY) <input type="checkbox"/> Yes <input type="checkbox"/> No			
DRIVER'S NAME (FIRST AND MIDDLE)		LAST NAME	DRIVER LICENSE NUMBER STATE
DRIVER'S ADDRESS (NUMBER)		STREET	DATE OF BIRTH DAMAGE AMOUNT MMDDYY .00
CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )
VEHICLE OWNER—PERSON OR COMPANY		DATE OF BIRTH	VEHICLE LICENSE PLATE STATE
ADDRESS		CITY	STATE ZIP CODE
VEHICLE IDENTIFICATION NUMBER		INSURANCE COMPANY NAME (NOT AGENT, UNDERWRITER, OR BROKER)	COMPANY NAIC NUMBER
INSURANCE POLICY NUMBER COVERING THE VEHICLE ACCIDENT (NOT CLAIM OR FILE NUMBER)		POLICY PERIOD From _____ To _____	
POLICY HOLDER'S NAME (IF DIFFERENT)		STREET ADDRESS	CITY STATE ZIP CODE

<input type="checkbox"/> In Traffic <input type="checkbox"/> Parked <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicyclist <input type="checkbox"/> Other (EXPLAIN, E.G., ROLLAWAY)			DRIVING FOR EMPLOYER <input type="checkbox"/> Yes <input type="checkbox"/> No
DRIVER'S NAME (FIRST AND MIDDLE)		LAST NAME	DRIVER LICENSE NUMBER STATE
DRIVER'S ADDRESS (NUMBER)		STREET	DATE OF BIRTH DAMAGE AMOUNT MMDDYY .00
CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )
VEHICLE OWNER—PERSON OR COMPANY		DATE OF BIRTH	VEHICLE LICENSE PLATE STATE
ADDRESS		CITY	STATE ZIP CODE
VEHICLE IDENTIFICATION NUMBER		INSURANCE COMPANY NAME (NOT AGENT, UNDERWRITER, OR BROKER)	COMPANY NAIC NUMBER
INSURANCE POLICY NUMBER COVERING THE VEHICLE ACCIDENT (NOT CLAIM OR FILE NUMBER)		POLICY PERIOD From _____ To _____	
POLICY HOLDER'S NAME (IF DIFFERENT)		STREET ADDRESS	CITY STATE ZIP CODE

INJURY/DEATH PROPERTY DAMAGE	NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	<input type="checkbox"/> Injured <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Deceased <input type="checkbox"/> Bicyclist <input type="checkbox"/> Pedestrian
	NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	<input type="checkbox"/> Injured <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Deceased <input type="checkbox"/> Bicyclist <input type="checkbox"/> Pedestrian
	OTHER PROPERTY DAMAGED (TELEPHONE POLES, FENCE, LIVESTOCK, ETC.)	DAMAGE AMOUNT _____.00
PROPERTY OWNER'S NAME AND ADDRESS		

I certify under penalty of perjury under the laws of the State of California that the information entered on this document is true and correct.

DATE	PRINTED NAME	SIGNATURE <b>X</b>
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ADDITIONAL INFORMATION ATTACHED

