

RideShare Accident Report Form

(Complete ALL Blanks and Boxes)

Date of Accident	Time	<input type="checkbox"/> A.M.	Report No.
		<input type="checkbox"/> P.M.	

DART VEHICLE INFORMATION – VEHICLE #1

Driver Name: _____ Vehicle Number: _____ Direction: _____
 Location (Street/Intersection): _____ City: _____
 Number of Passengers in Company Vehicle: _____ Number of Passengers in Other Vehicle: _____
 Number of Injured Passengers in Company Vehicle: _____
 Number of Injured Passengers In Other Vehicle: _____
 Number of Courtesy Cards Obtained: _____
Describe Damage to Company Vehicle: _____
Defective Equipment: Did you notice any equipment defects? Yes No
 Describe Defects: _____
 Whom did you notify? _____ When? _____

POLICE INFORMATION

POLICE INVESTIGATION Were Police at the scene of accident? Yes No
 Department Name: _____
 Officer's Name and Badge Number: _____
 Was a citation issued? Yes No
 To whom was citation issued: _____
 Reason: _____

OTHER VEHICLE /: Color: _____ Year: _____ Make: _____ Model: _____
 Body Style: _____ Plate Number: _____ State: _____

OTHER PROPERTY DAMAGED:

Description: _____
 Damage: _____

Owner's Name: _____ Phone: _____
 Address: _____ City/State/Zip: _____
 Driver's Name: _____ Phone: _____
 Address: _____ City/State/Zip: _____
 Operator License Number: _____
 Insurance: _____ Policy Number: _____
 Address: _____ City/State/Zip: _____
 Phone number: _____
 Driver's Physical Description: _____

*******INJURY INFORMATION*******
 *******Must complete INJURY QUESTIONNAIRE*******

DESCRIPTION OF ACCIDENT

Weather Conditions: Clear Cloudy Rain (light Heavy) Snow (Light Heavy)
 Fog (Light Heavy)

Road Surface Conditions: Dry Wet Mud Snow Ice Oil Other: (_____)

Light Conditions: Dawn Daylight Dusk

Darkness: Street Lights Street Lights not Working No Street Lights

Relation to Intersection: Near Side Far Side Within Between

Vehicle action: **Ours:** Straight Right turn Left turn Passing Stopping
Other: Straight Right turn Left turn Passing Stopping

Traffic control: **Ours:** Signal Stop Sign Yield Slow None Other
Other: Signal Stop Sign Yield Slow None Other

DESCRIPTION OF ACCIDENT

Was your view obstructed? No Yes By What? _____

Speed of vehicles when you first saw vehicle or person Ours: _____ MPH Other: _____ MPH

Speeds just before impact. Ours: _____ MPH Other: _____ MPH

Posted Speed Limit Ours: _____ MPH Other: _____ MPH

How far away was the other vehicle or person when you first saw it? _____ Feet

How far did the vehicles move after collision? Ours: _____ Feet Other: _____ Feet

Describe Accident in Detail: Begin with when you first notice danger and continue until police arrive on scene (if applicable). Use additional paper if necessary.

ACCIDENT DIAGRAM

Indicate On This Diagram What Happened
Use one of these outlines to sketch the scene of your accident, writing in street or highway names or numbers.



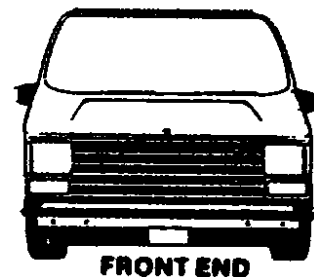
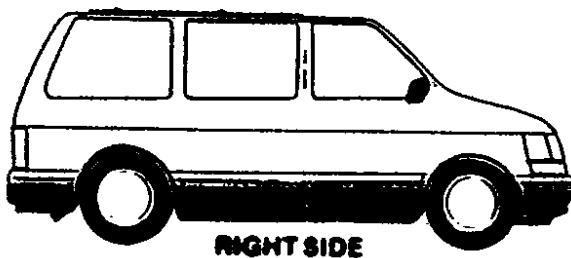
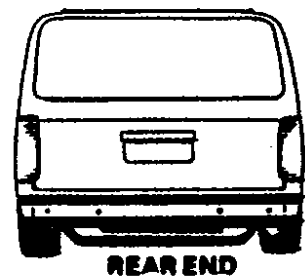
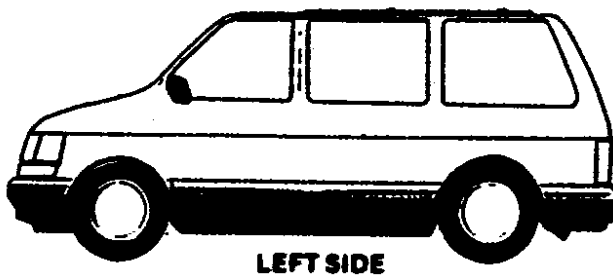
INDICATE NORTH BY ARROW



Street or Highway

Street or Highway

Street or Highway



Please note any damage to Company Vehicle above.

DRIVER SIGNATURE: _____ DATE: _____

DATE RECEIVED: _____ TIME RECEIVED: _____