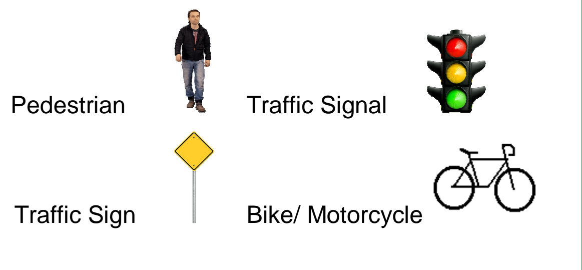
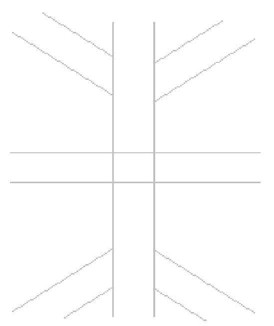
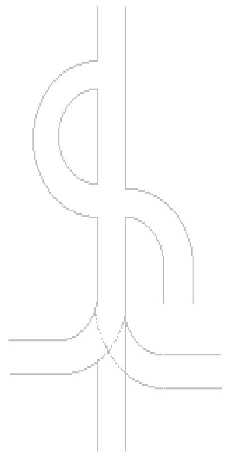


Fill in the light lines to correspond with the approximate road conditions at the accident site





Signature: ________________________

Date: ________________________

STATE OF VERMONT
OFFICE OF RISK MANAGEMENT
6 BALDWIN ST.,
MONTPELIER, VT 05633-3801
PHONE: 802-828-2899
FAX: 802-828-0410
sov.riskhelp@vermont.gov

AUTO ACCIDENT FORM

(To be completed at the accident scene)

Complete this accident form immediately after the accident

Call: 802-828-2899
Fax: 802-828-0410
Sov.riskhelp@vermont.gov

State of Vermont
Office of Risk Management
6 Baldwin St., Montpelier, VT 05633-3801
Phone: 802-828-2899 - Fax: 802-828-0410
Sov.riskhelp@vermont.gov

State Employee Information

Department: ______
Address: ______

Phone #: ______
Date/Time of Accident: ______
Location: ______
Make/Model of Vehicle: ______
Year of Vehicle: ______
Registration #: ______
Driver's Name: ______
Work Address: ______
Work Phone #: ______

Claimant Information

Driver's Name: ______
DOB: ______ SSN: ______
Date/Time of Accident: ______
Location: ______
Home Phone #: ______
Work Phone # ______
Cell Phone #: ______
Address: ______
Vehicle Owner Name: ______
Owner Work Phone #: ______
Owner Home/Cell #: ______
Owner Address: ______
Make/Model of Vehicle: ______
Year of Vehicle: ______
Registration #: ______
Insurance Name: ______
Insurance Phone # ______
Insurance Policy # ______

Injured Parties

Name: ______
Address: ______

Home Phone #: ______
Work Phone # ______
Cell Phone #: ______
Taken to Hospital from Scene? Yes ____ No ____
Was follow-up Treatment Required? Yes No
Name & Address of Care Provider: ______

Brief Description of Injury Sustained: ______

Name: ______
Address: ______

Home Phone #: ______
Work Phone # ______
Cell Phone #: ______
Taken to Hospital from Scene? Yes ____ No ____
Was follow-up Treatment Required? Yes No
Name & Address of Care Provider: ______

Brief Description of Injury Sustained: ______

Name: ______
Address: ______

Home Phone #: ______
Work Phone # ______
Cell Phone #: ______
Taken to Hospital from Scene? Yes ____ No ____
Was follow-up Treatment Required? Yes No
Name & Address of Care Provider: ______

Brief Description of Injury Sustained: ______

Witnesses

Name: ______
Address: ______
Phone #: ______
E-mail: ______

Name: ______
Address: ______
Phone #: ______

Incident Description
(Please continue on Separate sheet if needed)

What Drivers intended to do? (Check of for each driver)

Driver 1	Driver 2	Driver 3	
☐	☐	☐	Go straight Ahead
☐	☐	☐	Overtake and Pass
☐	☐	☐	Make Right Turn
☐	☐	☐	Make Left Turn
☐	☐	☐	Make U Turn
☐	☐	☐	Start in Traffic
☐	☐	☐	Start from Parked Position
☐	☐	☐	Back-up
☐	☐	☐	Remain Stopped in Traffic
☐	☐	☐	Remain Parked
☐	☐	☐	Get Out of Parked/Stopped Vehicle

Direction of Travel/Side of Street: ______
Lights On: Yes ____ No ____
Signal Given: Yes ____ No ____
Weather at time of Accident: ______
Condition of Road:
Were The Police Notified: Yes ____ No ____
City/Town: ______
Police Report #: ______
Driver Description of Accident (Please use separate paper if needed)