

# Automobile Accident Report

It is critical that incidents involving occupants, pedestrians, and other motorists be documented in an Automobile Accident Report. Doing so allows your business to investigate the cause of the incident, help identify the parties involved in the incident, and take corrective action to prevent such an incident from reoccurring. Notify your insurer of a possible claim and ensure you report the name and position of the person to whom you reported the claim. In the event of an injury to another party, alcohol and drug testing should be completed immediately.

This report form, hours of service, dash cam video, and photos taken of the incident should be retained on file to assist in defence against potential claims. A hard copy of the completed accident report form should be organized and kept on file. Where possible, an accident report form should also be stored in an electronic database that is backed up at regular intervals. Completing this report cannot in any way be construed as an admission of liability.

Administrative Details							
Business name							
Name of Driver							
Date of report							
Street address		City		Province		Postal code	
Report completed by				Title			
Email address				Phone number			


Key insurance personnel to contact in the event of an accident			
Name			Title (i.e. safety officer)
Insurance Company			Phone number



Incident Information							
Please note, this report captures information on up to two involved vehicles. Please ensure driver, vehicle, and insurance information is recorded for all additional involved vehicles and attached to this document.							
Date of incident		Time of incident		Hours of service		No. vehicles involved	
Location							
Province/State		Road/Street/Highway		Closest cross street/Mileage marker			
Property damage (other than to vehicles)	<input type="checkbox"/> Yes	Injured (even minor)	<input type="checkbox"/> Yes	Number of Inured Parties		Ambulance attended	<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No				<input type="checkbox"/> No
Incident description							

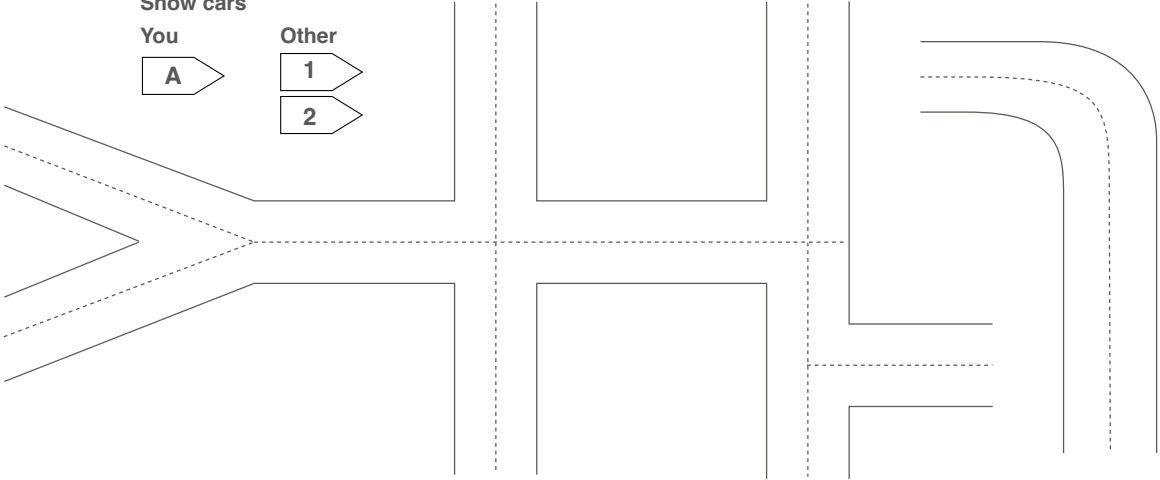
## Incident Sketch

Please illustrate details of the incident to support existing dashcam footage and photos taken on your camera or cellphone.  
If any street is more than two-lane or is one way only, please indicate.

**Show cars**

**You**  


**Other**  
  




Please include:

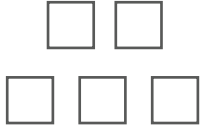
- Position of vehicle at time of collision
- Road sign(s)
- Intersection(s)
- Entrance(s) and/or exit(s)
- Curve(s)
- Uphill / Downhill
- Number of vehicles
- Label each street
- Indicate directions

Witness one information (if applicable)		Witness two information (if applicable)	
Name		Name	
Address		Address	
Phone number		Phone number	
Is witness a passenger of vehicle one or two?		Is witness a passenger of vehicle one or two?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional details		Additional details	

Circumstances

Weather conditions		Road Conditions	
Visibility		Lighting	
Additional details (i.e., speed, direction, other's speed, other's direction)			

Injuries (if applicable)

Position in the vehicle <div style="text-align: center; margin-top: 10px;">  </div>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Care received</td> <td style="width: 15%; text-align: center;"><input type="checkbox"/> Yes</td> <td style="width: 15%; text-align: center;"><input type="checkbox"/> No</td> </tr> <tr> <td>Departure ambulance</td> <td style="text-align: center;"><input type="checkbox"/> Yes</td> <td style="text-align: center;"><input type="checkbox"/> No</td> </tr> </table>	Care received	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Departure ambulance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Care received	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Departure ambulance	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Type of injury (i.e., bleeding, unconscious, broken members)							

## Vehicle One (your vehicle)

<b>Driver's License No.</b>			
Effective date		Expiry date	
First name			
Last name			
Street address			
City		Postal code	
Country		Province	
Home phone		Work phone	
Email address			

<b>Vehicle registration</b>				
Registered owner				
Address			Postal code	
City		Province		Country
Vehicle make		Year		Model
VIN No. (17 Digits)			Is your vehicle IRP plated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
License plate No.			License plate province	

**To be completed by Insurance Broker/Agent:**

**Vehicle rate class**

<b>Trailer one</b>			
Address			
City			
Postal code			
Country		Province	
Vehicle make		Year	
Serial number			
License plate			
Refrigerated trailer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Trailer two</b>			
Address			
City			
Postal code			
Country		Province	
Vehicle make		Year	
Serial number			
License plate			
Refrigerated trailer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Insurance certificate</b>				
Insurer		Insurance Company		
Policy number		Effective date		Expiry date
Name of Insured				
Address			Postal code	
City		Province		Country
Home phone		Work phone		
Agent/Broker		Phone		

## Vehicle Two (other involved vehicle)

<b>Driver's License No.</b>			
Effective date		Expiry date	
First name			
Last name			
Street address			
City		Postal code	
Country		Province	
Home phone		Work phone	
Email address			

<b>Vehicle registration</b>				
Registered owner				
Address			Postal code	
City		Province		Country
Vehicle make		Year		Model
VIN No. (17 Digits)				
License plate No.			License plate province	





**To be completed by Insurance Broker/Agent:**





**Vehicle rate class**

<b>Trailer one</b>			
Address			
City			
Postal code			
Country		Province	
Vehicle make		Year	
Serial number			
License plate			
Refrigerated trailer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Trailer two</b>			
Address			
City			
Postal code			
Country		Province	
Vehicle make		Year	
Serial number			
License plate			
Refrigerated trailer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Insurance certificate</b>				
Insurer		Insurance Company		
Policy number		Effective date		Expiry date
Name of Insured				
Address			Postal code	
City		Province		Country
Home phone		Work phone		
Agent/Broker		Phone		

Description of damages to Vehicle One or comments:	
	Show initial point of impact with an arrow.
	Motorcycle 
	Automobile 
	Tractor-trailer 
	Truck or other 

Description of damages to Vehicle Two or comments:	
	Show initial point of impact with an arrow.
	Motorcycle 
	Automobile 
	Tractor-trailer 
	Truck or other 

**Additional Information (if applicable)**

Police services			
Officer name			Badge number
Report No.			Phone number
Detachment			
Ticket received	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, reason: (i.e., type of infraction)			

Towing			
Company name			
Address of towing destination			Phone number
List of equipment			No. of employees

Spill					
Tank level <input type="checkbox"/> Empty <input type="checkbox"/> Quarter <input type="checkbox"/> Half <input type="checkbox"/> Three quarter <input type="checkbox"/> Full	Capacity			Measures taken	
	Environmental hazard	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Description	

Cargo				
Perishable	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measures taken	
Environmental hazard	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Description	
Class of hazardous	<input type="checkbox"/> Bulk	<input type="checkbox"/> Packaged	Trailer offloaded	<input type="checkbox"/> Yes <input type="checkbox"/> No

Attachments				
<input type="checkbox"/> Bill of lading	<input type="checkbox"/> Invoices	<input type="checkbox"/> Log books	<input type="checkbox"/> Photos	<input type="checkbox"/> Dashcam video
<input type="checkbox"/> Other (Specify)				

Completed by	
_____	_____
Print name	Date
_____	
Signature	

Authorized by	
_____	_____
Print name	Date
_____	
Signature	