


Accident Number		Agency NCIC No.		GEORGIA UNIFORM MOTOR VEHICLE ACCIDENT REPORT				County		Date Rec. by DOT	
Date		Day of Week <input type="checkbox"/> Sun <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> S		Time		Off. Arrived		Vehicles		Total Number of: Injuries Fatalities	
										Inside City Of:	
Road of Occurrence _____				At Its Intersection With _____				Corrected Report? Yes <input type="checkbox"/>			
1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St.				1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St.							
Not At Its Intersection But _____				<input type="checkbox"/> Miles 1 <input type="checkbox"/> North 3 <input type="checkbox"/> East Of: _____ <input type="checkbox"/> Feet 2 <input type="checkbox"/> South 4 <input type="checkbox"/> West				Suppl. To Original? Yes <input type="checkbox"/>			
And continuing in the direction checked above, the Next Reference Point is _____				1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St. 5 <input type="checkbox"/> Co. Line				Hit and Run? Yes <input type="checkbox"/>			
Driver #		LAST NAME		FIRST		MIDDLE		Driver #		LAST NAME	
										FIRST	
										MIDDLE	
Ped # <input type="checkbox"/>		Address						Ped # <input type="checkbox"/>		Address	
City		State		Zip		DOB		City		State	
										Zip	
										DOB	
Driver's License No.		Class		State		<input type="checkbox"/> Male <input type="checkbox"/> Female		Driver's License No.		Class	
										State	
										<input type="checkbox"/> Male <input type="checkbox"/> Female	
Posted Speed		Insurance Co.		Policy No.				Posted Speed		Insurance Co.	
										Policy No.	
Year		Make		Model		Telephone No.		Year		Make	
										Model	
										Telephone No.	
VIN		Vehicle Color						VIN		Vehicle Color	
Tag #		State		County		Year		Tag #		State	
										County	
										Year	
Trailer Tag #		State		County		Year		Trailer Tag #		State	
										County	
										Year	
<input type="checkbox"/> Same as Driver		Owner's Last Name		First		Middle		<input type="checkbox"/> Same as Driver		Owner's Last Name	
										First	
										Middle	
Address								Address			
City		State		Zip				City		State	
										Zip	
Removed By		<input type="checkbox"/> Request <input type="checkbox"/> List						Removed By		<input type="checkbox"/> Request <input type="checkbox"/> List	
Alcohol Test		Type		Results		Drug Test		Type		Results	
Driver Cond		Direction Of Travel		Vision Obscured		Contributing Factors		Driver Cond		Direction Of Travel	
Veh Cond		Veh Maneuver		Ped. Maneuver				Veh Cond		Veh Maneuver	
Most Harmful Event		Veh Class:		Veh Type:				Most Harmful Event		Veh Class:	
										Veh Type:	
Traffic Ctrl		Device Inoperative? <input type="checkbox"/> Yes <input type="checkbox"/> No						Traffic Ctrl		Device Inoperative? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Injured Taken To: _____						By: _____					
EMS Notified Time		EMS Arrival Time		Hospital Arrival Time		Photos Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No		By: _____			
Report By:		Department		Report Date		Checked By:		Date Checked			
Witness(es): Name		Address		City		State		Zip Code		Telephone No.	
DOT MICROFILM NUMBER (DO NOT WRITE IN THIS SPACE)											
COMMERCIAL VEHICLES ONLY											
Carrier Name						Carrier Name					
Vehicle #						Vehicle #					
Address						Address					
City						City					
State						State					
Zip						Zip					
No. of Axles		G.V.W.R.		Fed. Reportable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Cargo Body Type		No. of Axles		G.V.W.R.	
Vehicle Config.		I.C.C.M.C. #		U.S. D.O.T. #		Interstate <input type="checkbox"/> Intrastate <input type="checkbox"/>		Vehicle Config.		I.C.C.M.C. #	
C.D.L.? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		C.D.L. Suspended? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						C.D.L.? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		C.D.L. Suspended? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Vehicle Placarded? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hazardous Materials? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						Vehicle Placarded? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hazardous Materials? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Released? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								Released? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
If YES, Name or 4 Digit Number from Diamond or Box: _____						If YES, Name or 4 Digit Number from Diamond or Box: _____					
1 Digit Number from Bottom of Diamond: _____						1 Digit Number from Bottom of Diamond: _____					
___ Ran Off Road ___ Down Hill Runaway ___ Cargo Loss or Shift ___ Separation of Units						___ Ran Off Road ___ Down Hill Runaway ___ Cargo Loss or Shift ___ Separation of Units					

[illegible]