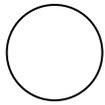


Accident Number		Agency NCIC No.		GEORGIA UNIFORM MOTOR VEHICLE ACCIDENT REPORT				County		Date Rec. by DOT					
Date	Day of Week <input type="checkbox"/> Sun <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> S			Time		Off. Arrived		Vehicles		Total Number of: Injuries Fatalities					
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 <input type="checkbox"/> Feet 2 <input type="checkbox"/> South 4 <input type="checkbox"/> West										Suppl. To Original? 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. 5 <input type="checkbox"/> Co. Line										Hit and Run? 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					
Driver #	LAST NAME			FIRST		MIDDLE		Driver #	LAST NAME			FIRST		MIDDLE	
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	Alcohol Test	Type	Results	Drug Test	Type	Results				
Driver Cond	Direction Of Travel		Vision Obscured	Contributing Factors		Driver Cond	Direction Of Travel		Vision Obscured	Contributing Factors					
Veh Cond	Veh Maneuver		Ped. Maneuver	Contributing Factors		Veh Cond	Veh Maneuver		Ped. Maneuver	Contributing Factors					
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	Vehicle #			Carrier Name	Vehicle #										
Address	City		State		Zip		Address	City		State		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.	Fed. Reportable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Cargo Body Type					
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. #	U.S. D.O.T. #		Interstate <input type="checkbox"/> Intrastate <input type="checkbox"/>					
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														

REMARKS:

INDICATE ON THIS DIAGRAM WHAT HAPPENED **INDICATE NORTH** 

CITATIONS – VEHICLE # ____ CITATIONS – VEHICLE # ____

First Harmful Event	Traffic-Way Flow	Weather	Surface Cond.	Light Cond.	Manner of Collision	Location at Area Of Impact	Road Comp.	Road Def.	Road Character	Construction / Maintenance Zone
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VEH # ____		VEH # ____		SKID DISTANCE BEFORE IMPACT	_____	AFTER	_____	Width of Road _____
Number of Occupants			VEH.		VEH.			
Point of Initial Contact			VEH.		VEH.			
Damage To Vehicles				VEH.	VEH.			

Damage Other Than Vehicle:	Owner:	AGE	SEX	VEH #	POS	INJURY	TAKEN FOR TREAT.	EJECT	SAFETY EQUIP.	EXTRIC.	AIR BAG			
Occupants (list below):	Driver # Or Pedestrian #													
	Driver # Or Pedestrian #													
LAST NAME	FIRST	ADDRESS	CITY	STATE	ZIP	X	X	X	X	XXXX	XXXX	XXXX	XXXX	XXXX