

# Driver Motor Vehicle Accident Report

Ambulance Service Name _____	Date of Accident _____
------------------------------	------------------------

Time _____	Weather Conditions _____
------------	--------------------------

Location of Accident \_\_\_\_\_

Road Conditions _____	Posted Speed Limit _____
-----------------------	--------------------------

Type of Surface _____	Amount of Traffic: High <input type="checkbox"/> Med <input type="checkbox"/> Low <input type="checkbox"/>
-----------------------	--

Investigating Police Officer _____	Detachment _____
------------------------------------	------------------

Was Ambulance on call at time of Accident	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, state Emergency code status 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
---	------------------------------	-----------------------------	---

Was Patient aboard Ambulance at time of Accident	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
--	------------------------------	-----------------------------	--

<b>AMBULANCE</b>	<b>OTHER VEHICLE OR PROPERTY</b>
------------------	----------------------------------

Driver's Name _____	Owner's Name _____
---------------------	--------------------

Driver's Address, (Street, Town, City, Prov. & Postal code ) _____	Owner's Address, (Street, Town, City, Prov. & Postal code ) _____
--	---

Driver's Licence No. _____	Class _____	Driver's Name _____
----------------------------	-------------	---------------------

Driver's Age _____	Driver's Address, (Street, Town, City, Prov. & Postal code ) _____
--------------------	--

Years of Driving experience \_\_\_\_\_

Hours on Duty Prior to Accident \_\_\_\_\_

Vehicle Type _____	Plate Number _____	Driver's Licence No. _____
--------------------	--------------------	----------------------------

OASSIS Number _____	Vehicle Type _____ Plate Number _____
---------------------	---------------------------------------

E.H.S. Vehicle No. _____	Insurance Company _____
--------------------------	-------------------------

Insurance Company _____	Insurance Company Address _____
-------------------------	---------------------------------

Policy No. \_\_\_\_\_

Damage to Vehicle \_\_\_\_\_

Policy No. \_\_\_\_\_

Estimated cost to Repair \$ _____	Damage to Vehicle or Property _____
-----------------------------------	-------------------------------------

Approximate Speed \_\_\_\_\_

Check if Lights were on	Front <input type="checkbox"/>	<input type="checkbox"/>	Rear <input type="checkbox"/>	
-------------------------	--------------------------------	--------------------------	-------------------------------	--

Emergency Lights on ?	Yes <input type="checkbox"/>	<input type="checkbox"/>	No <input type="checkbox"/>	Estimated cost to Repair \$ _____
-----------------------	------------------------------	--------------------------	-----------------------------	-----------------------------------

Emergency Siren on ?	Yes <input type="checkbox"/>	<input type="checkbox"/>	No <input type="checkbox"/>	Check if Lights were on Front <input type="checkbox"/> <input type="checkbox"/> Rear <input type="checkbox"/>
----------------------	------------------------------	--------------------------	-----------------------------	---

Was Driver Injured ?	Yes <input type="checkbox"/>	<input type="checkbox"/>	No <input type="checkbox"/>	Estimated speed _____
----------------------	------------------------------	--------------------------	-----------------------------	-----------------------

Type of injury. _____	Was Driver Injured ? Yes <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/>
-----------------------	--

Was driver using seatbelt ?	Yes <input type="checkbox"/>	<input type="checkbox"/>	No <input type="checkbox"/>	
-----------------------------	------------------------------	--------------------------	-----------------------------	--

Were others using seatbelt ?	Yes <input type="checkbox"/>	<input type="checkbox"/>	No <input type="checkbox"/>	
------------------------------	------------------------------	--------------------------	-----------------------------	--

Names/Addresses of all occupants (indicate if injured) _____	Names/Addresses of all occupants (indicate if injured) _____
--	--

<b>1</b> _____	<b>1</b> _____
----------------	----------------

<b>2</b> _____	<b>2</b> _____
----------------	----------------

<b>3</b> _____	<b>3</b> _____
----------------	----------------

**Names and Addresses of witnesses (other than occupants of vehicles)**

**1** \_\_\_\_\_

**2** \_\_\_\_\_

