



**Review accident kit for
completeness and accuracy**

ACCIDENT KIT

Report the accident immediately!



Please follow these quick steps:

- Secure the scene
- Call the police immediately
- Discuss only with police or authorized company representative
- Do not admit responsibility
- Complete this form
- Take photos
- Do not repair vehicle unless cleared by the DMC claim department

The Accident

Date: _____ Time: _____ AM/PM
Location: _____
City: _____ State: _____
Description: _____

Client Driver Information

Driver's Name: _____
Driver's License #: _____
Address: _____
City: _____ State: _____
Phone: _____

Equipment Information

Power Unit

Make: _____ Model: _____
Year: _____ Unit #: _____
VIN: _____
Damage: _____

Trailer

Make: _____ Model: _____
Year: _____ Unit #: _____
VIN: _____
Damage: _____
Loaded? Yes / No Cargo Damaged? Yes / No
Cargo: _____

Was Equipment Towed? Yes / No

If so, where: _____

Fuel Spill? Yes / No Hazmat Assignment? Yes / No

If so, who: _____

Police Information

Did Police make a report? Yes / No

Police Dept: _____

Officer's Name: _____

Report #: _____

Citation(s) Issued? Yes / No

Who was cited: _____

Citation(s): _____

Other Vehicle #1

Driver Name: _____
Driver's License: _____
Address: _____
City: _____ State: _____
Phone: _____
DOB: ____ / ____ / ____ Injured: Yes / No
Make: _____ Model: _____
Year: _____ VIN: _____
Plate #: _____ State: _____
Insurance Co.: _____
Policy #: _____
Damage: _____
Towed? Yes / No
Number of Passengers: _____ Injuries? Yes / No

Other Vehicle #2

Driver Name: _____
Driver's License: _____
Address: _____
City: _____ State: _____
Phone: _____
DOB: ____ / ____ / ____ Injured: Yes / No
Make: _____ Model: _____
Year: _____ VIN: _____
Plate #: _____ State: _____
Insurance Co.: _____
Policy #: _____
Damage: _____
Towed? Yes / No
Number of Passengers: _____ Injuries? Yes / No

Other Property Damage

Owner Name: _____
Address: _____
City: _____ State: _____
Phone: _____
Type of Property Damaged: _____
Description of Damage: _____
Insurance Co.: _____
Policy #: _____

Injured Person

Which Vehicle: _____

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Treated at scene? Yes / No Trans to hospital? Yes / No

Injured Person

Which Vehicle: _____

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Treated at scene? Yes / No Trans to hospital? Yes / No

Injured Person

Which Vehicle: _____

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Treated at scene? Yes / No Trans to hospital? Yes / No

Injured Person

Which Vehicle: _____

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Treated at scene? Yes / No Trans to hospital? Yes / No

Witness

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Email: _____

Witness

Name: _____
Address: _____
City: _____ State: _____
Phone: _____ Age: _____
Email: _____