

Immediately after an accident, fill out this form and send it to:

MAINE COUNTY COMMISSIONERS ASSOCIATION
SELF-FUNDED RISK MANAGEMENT POOL
ACCIDENT REPORT -- AUTO AND TRUCK

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

CLIENT

NAME:	PHONE:	DRIVER NAME:	PHONE:	DOB:		
ADDRESS:		ADDRESS:		NO. YEARS WITH COMPANY:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:	DRIVER'S LICENSE#:

VEHICLE

MAKE OF YOUR VEHICLE:	YEAR:	MODEL:	SERIAL NUMBER:	LICENSE NO.:	WHERE VEHICLE CAN BE SEEN:
TRAILER (IF APPLICABLE):	YEAR:	MODEL:	AREA OF DAMAGE:	USED FOR BUSINESS: <input type="checkbox"/> YES <input type="checkbox"/> NO	ESTIMATED COST TO REPAIR: \$

ACCIDENT

DATE OF LOSS:	TIME OF LOSS:	LOCATION (STREET OR HIGHWAY):	CITY:	STATE:	
WERE POLICE CALLED TO THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICE DEPT. CALLED:	DRIVER:	ARRESTED:	TICKETED:	VIOLATION:
NAME OF OFFICER:	BADGE NUMBER:	STATION ADDRESS:	STATE:	ZIP:	

CLAIMANT #1

OWNER OF OTHER VEHICLE:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
DRIVER, IF OTHER THAN ABOVE:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
MAKE OF VEHICLE:	YEAR:	MODEL:	LICENSE NO.:	AREA OF DAMAGE:	ESTIMATE OF DAMAGE: \$	WHERE VEHICLE CAN BE SEEN:

CLAIMANT #2

OWNER OF OTHER VEHICLE:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
DRIVER, IF OTHER THAN ABOVE:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
MAKE OF VEHICLE:	YEAR:	MODEL:	LICENSE NO.:	AREA OF DAMAGE:	ESTIMATE OF DAMAGE: \$	WHERE VEHICLE CAN BE SEEN:

PROPERTY DAMAGE -- OTHER THAN AUTO (i.e. FENCE, CANOPY)

OWNER OF PROPERTY:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
DESCRIBE DAMAGED PROPERTY:	LOCATION OF PROPERTY:	CITY:	STATE:	EXTENT OF DAMAGE:	

WITNESS INFORMATION

NAME:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
NAME:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

NOTE: PLEASE COMPLETE REVERSE SIDE

PERSONS INJURED

NAME:		AGE:	NAME:		AGE:
ADDRESS:		PHONE:	ADDRESS:		PHONE:
CITY:		STATE:	ZIP:	CITY:	
STATE:		ZIP:	STATE:		ZIP:
OCCUPATION:		WHERE TAKEN:		OCCUPATION:	
WHERE TAKEN:		WHERE TAKEN:		WHERE TAKEN:	
<input type="checkbox"/> FATALITY <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> BLEEDING OR DISTORTED WOUND <input type="checkbox"/> IN YOUR VEHICLE <input type="checkbox"/> UNCONSCIOUSNESS <input type="checkbox"/> IN CLAIMANT VEHICLE <input type="checkbox"/> NO VISIBLE INJURY – COMPLAINED OF PAIN <input type="checkbox"/> OTHER			<input type="checkbox"/> FATALITY <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> BLEEDING OR DISTORTED WOUND <input type="checkbox"/> IN YOUR VEHICLE <input type="checkbox"/> UNCONSCIOUSNESS <input type="checkbox"/> IN CLAIMANT VEHICLE <input type="checkbox"/> NO VISIBLE INJURY – COMPLAINED OF PAIN <input type="checkbox"/> OTHER		

ADDITIONAL REMARKS

DESCRIBE ACCIDENT

VEHICLES → 1 2 ← PEDESTRIAN ○←

	<p>ACCIDENT DIAGRAM:</p> <p style="text-align: right;">INDICATE NORTH</p> <div style="text-align: center;">  </div> <p style="text-align: right;">BY ARROW</p>
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WHAT STREET WERE YOU ON?		CLAIMANT 1:	CLAIMANT 2:
WHAT DIRECTION WERE YOU TRAVELING?		CLAIMANT 1:	CLAIMANT 2:
WEATHER CONDITIONS: <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY <input type="checkbox"/> FOGGY <input type="checkbox"/> SNOWY <input type="checkbox"/>		TRAFFIC CONDITIONS: <input type="checkbox"/> LIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY	
SPEED LIMIT:	WERE YOU FAMILIAR WITH THE AREA?: <input type="checkbox"/> YES <input type="checkbox"/> NO	TRAFFIC CONTROLS:	

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? YES NO
2. IN MY OPINION, ARE WE AT FAULT FOR THIS ACCIDENT? YES NO

DATE OF THIS REPORT:	SIGNATURE AND TITLE:
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