							New Jersey ccident Report			Print or Type onl			Agency Use	only - Loc #.	TYPE OF STATE VEHICLE 1. Subcompact * Specialized		
Accident Date		Day of We	ek	Time	AM PM	# of Vehicl		# Killed	# Injur	red	Name of Po	lice Dept or I	Investigating	Agency	2. Compact equipment su 3. Passenger cars/station wagons. as bulldosers, 4. Vans used for transporting people graders, stree		
Location of Accident (Municipality) Route # or Name of Street							ROAD I				on, Collision was Between:			5. All other Vans sweepers, back- 6. Utility Vehicles & pick up trucks 7. Light Trucks - Wt. 5,000 - 10,000 Lbs. lawnmowers &			
County Intersecting St					ting Street	g Street, Road , or Railroad				ROAD 2					8. Medium Trucks - Wt. 10,001 - 20,000 Lbs. 9. Heavy Trucks - Wt. 20,001 - 45,000 Lbs. 10. Extra Heavy Trucks - Wt. over 45,000 Lbs.		
STATE Was Citation Issued? Cita VEHICLE 1 YES NO					ation to Whom? State Driver Other Driver Veh					hicle # -					11. Misc Equipment * ** Fire engines, 12. Buses ambulances, 13. All other Motor vehicles ** Etc.		
State Driver (Last Name) (First Name) (Middle Initial) Phone Number											ENVIRONMENTAL CONDITIONS						
Home Address (Number) (Street)							(City)			·	(State) (Zip)			Weather 1. Clear 2. Rain 3. Snowy 4. Fog 5. Other			
Social Security Number Age Sex					Driver's License Number					State			Dept. / Div.		Surface I. Dry 2. Wet 3. Snow 4. Icy 5. Other		
Make of Vehicle Year of Vehicle				Lice	License Plate Number / SG #					Vehicle Owner / Lessor					Light 1. Daylight 2. Dawn or Dusk Condition 3. Dark (Street lights on) 4. Dark (Street lights off) 5. Dark (No Lights)		
Employee's Workstati	on A	ddress (Nu			Street)		((City)		(S	tate)	(Zip)			Collision 1. Pedestrian 2. Other motor Veh. Involved 3. Overturned		
OTHER VEHICLE 2				ance Con	mpany Policy Numb						licy Number	er			With 4. Pedalcycle 5. Moped or Motorcycle 6. Animal 7. Fixed Object 8. Other object		
Other Driver (river (Last Name) (First Name) (Middle Initial) Phone Number ()										Defensive Driving within the last 36 Months? 1 - Yes						
Driver's Address (Nu	mber)		(St	reet)		(Ci	ty)			(S	tate)	(Zip)			2 - No Date / / ** ** If "YES" Date must be indicated		
Birthdate Eye Co	olor	Sex	Dri	iver's Lic	ense Num	ber		State	Make o	of Vehic	cle Year	License Pla	ate #	State	Information in this area to be Provided by Employee's Supervisor.		
Vehicle Owner (Last Name / Company) (First Name) (Middle Initial) Phone Numbe ()									umber)	<u> </u>	- · · · · · · · · · · · · · · · · · · ·		STATE DRIVER INJURIES 0. First aid or other non recordable incident				
Owner's Address (N	umbe	er)	(St	reet)		(Ci	y)		· · · · · ·	(S	tate)	(Zip)			Medical Treatment Medical Treatment - Employee transferred		
Injured ,	- L	iame & Add			Tel. NO. () Tel. NO.			State	Passenger in: tate Car Other Ca		Ped	Extent of injury: Severe Slight		3. Medical Treatment - Employee terminated 4. Loss of conciousness - no medical treatment 5. Lost work day case			
(Other Than State Driver)	~ _	ame & Add		 -		() Tel. No			State Passe	Passenger in: State Car Other Ca Passenger in:		·	Extent of injury: Severe Slight Extent of injury:		6. Lost work day case - Employee transferred 7. Lost work day case - Employee terminated 8. Fatality Fatality Date/		
		- · · · · · · · · · · · · · · · · · · ·			·				State		Other Car	Ped Loss of worl	Sever		Workdow on Market 17.		
4. Other (de	ng to fine)_ nly -	5. Striping	akfast, 6. Sand	lunch, or a	ow Plowin	l place of work			or perma	anent) —	•	Estimated Count work di would have w	ays (consect orked, but c injury or illn	Actual utive or not). En ould not becaus ess. Don't cour	workdays on Modified Job Estimated Actual Enter total of 1. Days assigned to temporary job. 2. Part time days on regular job. 3. Days on regular job but unable to perform all normally connected duties.		

Indicate North By Arrow In Circle Above	BRIDGE	NST	RUCTIONS: Give Street Name: (1) Number each vehicle and	et Closely Resembles the Roadway Where the Accident Occident Code or Route Numbers, Directions and Locations of Objects invision direction of travel by arrow—Ohn of each vehicle before accident—Obted line after accident—Ohy—O—O, Redestrian by—ORALIFORD RESERVED TRAFFIC CIRCLE	olved.
DESCRIPTION OF ACCIDENT PRINT CLEARLY!	Refer to vehicles by number - Include description of proper	Give direction and app ty damage other than ve	roximate speed of each ve chicle damage.	V1 V2 INDICATE INITIAL IMPACT DAMAGE FRONT	Did airbag deploy; Yes No
		ADD	SUPPLEMETAL SHEETS AS N	AREAS DAMAGED V1 V2 10 Undercarr.	
W NAME ADDRESS I NAME ADDRESS NAME ADDRESS NAME ADDRESS S	TELEPHONE NUMBER R SIGNATUR	OF STATE DRIVER COMPLETING THIS FORM E OF DRIVER'S SUPERVISOR E OF PLEET LIAISON OFFICER	DATE TITLE & ORGANIZATION DATE TITLE DATE TITLE	TELEPHONE NUMBER () TELEPHONE NUMBER () TELEPHONE NUMBER	

POLICE REPORT TO BE FORWARDED AS SOON AS POSSIBLE