

# COMMONWEALTH OF VIRGINIA

## REPORTING AGENCY'S INFORMATION

AGENCY NAME:	CELL PHONE:
ADDRESS:	BUSINESS PHONE:
CONTACT PERSON:	OTHER PHONE:
AGENCY REFERENCE #:	E-MAIL:

## ACCIDENT DETAILS

ACCIDENT DATE:	ACCIDENT TIME:
ACCIDENT LOCATION:	
ACCIDENT REPORTED TO STATE POLICE (CHECK ONE) <span style="float: right;">YES: <input type="checkbox"/> NO: <input type="checkbox"/></span>	
NAME OF POLICE DEPARTMENT:	
VEHICLE DRIVER:	POLICE REPORT NUMBER:
VEHICLE DRIVER'S LICENSE #:	
VEHICLE DRIVER CONTACT PHONE NUMBER:	
VEHICLE POOL#:	VEHICLE LICENSE PLATE #:
VEHICLE ID # (VIN)	
VEHICLE'S CURRENT LOCATION (FOR INSPECTION):	
ACCIDENT DESCRIPTION AND/OR DIAGRAM:	

## OTHER DAMAGED PROPERTY

<b>OTHER VEHICLE:</b>	<b>OTHER PROPERTY:</b>
DRIVER'S NAME:	OWNER'S NAME:
DRIVER'S PHONE:	OWNER'S ADDRESS:
DRIVER'S LICENSE #:	PROPERTY LOCATION:
DRIVER'S ADDRESS:	EXTENT OF PROPERTY DAMAGE:
INSURANCE COMPANY:	
INSURANCE POLICY #:	

## WITNESSES/PASSENGERS

NAME	PHONE	WITNESS	PASSENGER	AGENCY VEH	OTHER VEH
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## INJURED

NAME	PHONE	AGENCY VEH	OTHER VEH	EXTENT OF INJURY:
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

REPORTED BY (NAME):	(INITIALS)	REPORTED TO (NAME):	(INITIALS)	DATE:
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*Note: When submitting form electronically, your initials here will serve as your electronic signature*