

Condition at the Time of the Accident – circle one for each category

LIGHT CONDITION

1. Daylight
2. Dark
3. Dark w/Street Light
4. Dawn or Dusk

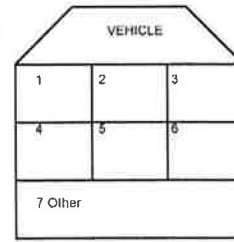
WEATHER CONDITION

1. Clear
2. Cloudy
3. Rain
4. Snow or Ice
5. Fog or Mist
6. Sleet

ROAD CONDITION

1. Dry
2. Snow or Ice
3. Wet
4. Gravel
5. Slush
6. Muddy
7. Oily
8. Other

Place an X where you were seated in this vehicle



Cycle Or Bicycle

Accident Date _____

Time of Accident _____

Where were you coming from prior to the accident?

Where were you going ?

On this trip, how long have you been driving/riding prior to this accident?

How often do you drive this vehicle?

As far as you know, was there anything wrong with this vehicle prior to the accident?

No Yes, What? _____

Who else was with you at the time of the accident?

Were you wearing your seat belt? No Yes

What were you doing prior to the accident?

Did anything interfere with your view at the time of the accident?

No Yes

Were there any other vehicles nearby at the time of the accident?

No Yes

Did any of these vehicles contribute to the accident?

No Yes, How? _____

How fast were you traveling?

What indicated to you that an accident would occur?

Did you do anything to avoid this accident, i.e., braking, turning, etc.?

In your opinion, why did this accident occur?

Have any of the vehicles been moved since the accident?

No Yes, How? _____

Have you taken any medication or alcohol within the 6 hours prior to the accident?

No Yes, What? _____

SIGNATURE _____

DATE _____

OFFICER SIGNATURE _____

DATE _____