



# OREGON TRAFFIC CRASH AND INSURANCE REPORT

Tear this sheet off your report, read and carefully follow the directions.

**ONLY drivers involved in a crash resulting in any of the following MUST file a *Crash & Insurance Report*:**

- Damage to your vehicle is over \$2500
- Injury (No matter how minor)
- Death
- Damage to any one person's property over \$2500
- Any vehicle has damage over \$2500 and any vehicle is towed from the scene as a result of damages

Oregon law requires these reports be filed within **72 hours** of the crash. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the crash to DMV, it may result in suspension of your driving privileges. **If the police department files a police report, you are still required to file your own Crash and Insurance Report with DMV. When required to report, even if you are licensed in another state, or you are not an Oregon resident, you still must file a report with Oregon DMV.** DMV does not determine fault in a crash, but does post the crash to the driving record of those drivers required to report, unless the vehicle is parked. **If you have questions, please call DMV Crash Reporting Unit at (503) 945-5098.**

## INSTRUCTIONS

**PRINT OR TYPE ALL INFORMATION.** (Use black or dark blue ink and press firmly.)

- Complete both sides of the form.
- If additional vehicles were involved in the crash, complete the attached *Supplemental Report* (Form 735-32B), or on a blank piece of paper, write all the information as requested in Section 4, the "Other Driver" Section.
- DMV Headquarters will verify the insurance information submitted. Complete the insurance section or a suspension of your driving privileges may occur.

## SECTION 1

**DATE, LOCATION AND TIME** — Clearly identify the date, location and time of the crash. The correct date, location and time is critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

## SECTION 2

Your vehicle is Vehicle #1. Complete ALL fields. **Provide Insurance company name (not agent), policy number, and Vehicle identification number (VIN).** Failure to provide complete insurance and vehicle information may result in DMV issuing Notice of Suspension due to incomplete information.

## SECTION 3

Failure to complete this section may result in DMV sending Notice of Suspension for failure to file a report. Principle purpose of driving and being paid to drive does not mean driving to reach a destination to perform a service. Property: Includes, but is not limited to, fixed or real property, landscaping, signs, parked vehicles, and animals.

**COMMERCIAL MOTOR VEHICLE OPERATORS:** In addition to this report, Oregon Administrative Rule requires that **Form 735-9229, *Motor Carrier Crash Report*, MUST** be filed within 30 days of a commercial motor vehicle crash when there is a FATALITY, INJURY (requiring treatment away from the scene), or when a vehicle is TOWED from the scene because of disabling damage. Form 735-9229 (attached on back) MUST be submitted with *Oregon Traffic Crash and Insurance Report* (Form 735-32) to DMV. Call (503) 986-3507 for questions regarding the *Motor Carrier Crash Report*.

[You may now file the Motor Carrier Crash Report at: www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/](http://www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/)

## SECTION 4

**OTHER VEHICLE (# 2)** — Completion of this information will help DMV match all driver's crash reports more efficiently. If additional vehicles were involved in the crash, complete attached *Supplemental Report* (Form 735-32B).

## SECTION 5

**DESCRIPTION AND SIGNATURE** — Describe what happened. It is important for you to sign and date the form. Only a family member may sign and date this form on behalf of a driver when the driver is incapacitated or physically unable to sign. No other signatures will be accepted.

## COMPLETING AND FILING REPORT

**HOW TO SUBMIT A REPORT TO DMV:**

- Email to OregonDMVAccidents@odot.oregon.gov
- Fax to 503-945-5267
- Mail to DMV Crash Reporting Unit 1905 Lana Ave NE, Salem, Oregon 97314
- Deliver to a DMV office

**Keep a copy of the report and documentation that shows when you submitted your report to Oregon DMV.** Under ORS 802.220(5), DMV is not authorized to provide you with a copy of the report that you file. If submitting by:

- Email, DMV sends an autoreply that your email was received. Save that autoreply.
- Fax, many fax machines provide the option to generate a fax confirmation report. Save that report.
- DMV Field Office, request and save that receipt.

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY CAN NOT REQUIRE REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

# TOTALED VEHICLE NOTICE

## DEFINITIONS AND INSTRUCTIONS FOR TOTALED VEHICLES

IF YOUR CRASH HAS RESULTED IN A "TOTALED" VEHICLE, YOU ARE REQUIRED BY LAW TO FOLLOW APPROPRIATE INSTRUCTIONS IN THIS NOTICE.

### DEFINITION OF "TOTALED" VEHICLE

"Totaled Vehicle" or "Totaled" as defined in Oregon law (ORS 801.527) means:

- A vehicle that is declared a total loss by an insurer who is obligated to cover the loss or a vehicle that the insurer takes possession of or title to.
- A vehicle that has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80% of the retail market value prior to the damage. "Retail market value" is defined as the amount shown in publications used by financial institutions (banks or lenders) in this state.
- A vehicle that is stolen, if it is not recovered within 30 days of theft and the loss is not covered by an insurer. In this situation, you must notify DMV within 60 days of the theft.

### ▼ FOLLOW THESE INSTRUCTIONS IF YOUR VEHICLE IS TOTALED ▼

If your vehicle is totaled, in addition to completing the crash report, follow the instruction that is applicable to your case. **Either:**

1. SURRENDER the title to the insurer if the damage is covered by an insurer who declares the vehicle to be a "total loss," and the insurer takes possession of the vehicle; **or**
2. SURRENDER the title to DMV and apply for salvage title if the damage is covered by an insurer who declares the vehicle to be a "total loss," but you keep possession of the vehicle; **or**
3. SURRENDER the title to DMV and apply for salvage title if the damage was not covered by an insurer and the estimated cost of repair is at least 80% of the retail market value of the vehicle before the damage; **or**
4. NOTIFY DMV that your vehicle has been totaled if, for some reason, you are unable to obtain the title for surrender. You must provide DMV with a signed statement which includes:
  - A description of the vehicle which includes the year model, make, plate number and vehicle identification number.
  - A statement indicating the vehicle has been totaled.
  - A statement that you are unable to obtain the title and why.

**DO NOT** SUBMIT THE TITLE WITH THE CRASH REPORT. You can obtain the *Application for Salvage Title* (Form 735-229) from any DMV office, by calling (503) 945-5000, or on-line at [www.oregondmv.com](http://www.oregondmv.com). Application instructions and fee information are on the back of the form 735-229. If you have questions about salvage titles, call (503) 945-5122.

**NOTE:** It is a Class A misdemeanor with a penalty of imprisonment and/or fine if you fail to comply with the above requirements. (ORS 819.012)



# OREGON TRAFFIC CRASH AND INSURANCE REPORT

COMPLETE BOTH SIDES

Complete this form if the traffic crash occurred on a highway or premise open to the public and meets at least one of the reporting requirements outlined in Section 3. Failure to report when required may result in DMV issuing Notice of Suspension. Call 503-945-5098 for assistance in completing the report.

|                             |  |  |  |   |  |  |   |                               |                                 |  |
|-----------------------------|--|--|--|---|--|--|---|-------------------------------|---------------------------------|--|
| SECTION 1                   | CRASH DATE   | DAY OF WEEK<br><input type="radio"/> M <input type="radio"/> T <input type="radio"/> W <input type="radio"/> T <input type="radio"/> F <input type="radio"/> S <input type="radio"/> N | TIME OF DAY<br><input type="radio"/> AM<br><input type="radio"/> PM  | COUNTY  | DMV USE ONLY   |  |   | ALIR <input type="checkbox"/> | INS CO <input type="checkbox"/> |  |
|                             | ROAD ON WHICH CRASH OCCURRED (Name of street, road or route) |  | MILE POST  | TYPE OF CRASH - The crash involved one or more of the following: (Mark all that apply)  |  |  |   |                               |                                 |  |
|                             | NAME OF NEAREST INTERSECTING ROAD                            |  | <input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W | <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W | <input type="checkbox"/> Two vehicles                        | <input type="checkbox"/> ATV / Snowmobile        | <input type="checkbox"/> Parked vehicle |                               |                                 |  |
| NAME OF NEAREST CITY / TOWN |  | <input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W   | <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W  | <input type="checkbox"/> More than two vehicles   | <input type="checkbox"/> Motorcycle                          | <input type="checkbox"/> Overturned vehicle      |   |                               |                                 |  |
|                             |  | <input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W   | <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W  | <input type="checkbox"/> Fatality   | <input type="checkbox"/> Motor Home / RV                     | <input type="checkbox"/> Animal                  |   |                               |                                 |  |
|                             |  | <input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W   | <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W  | <input type="checkbox"/> Bicycle  | <input type="checkbox"/> Motorized Scooter                   | <input type="checkbox"/> Fixed object / property |   |                               |                                 |  |
|                             |  | <input type="checkbox"/> WITHIN _____ FEET <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W   | <input type="checkbox"/> NEAR _____ MILES <input type="radio"/> N <input type="radio"/> S <input type="radio"/> E <input type="radio"/> W  | <input type="checkbox"/> Pedestrian   | <input type="checkbox"/> Personal (assisted) mobility device | <input type="checkbox"/> Other _____             |   |                               |                                 |  |

Complete ALL fields. Failure to provide complete information may result in DMV issuing Notice of Suspension.

|                               |   |                               |             |                         |                      |               |   |
|-------------------------------|---|-------------------------------|-------------|-------------------------|----------------------|---------------|---|
| SECTION 2<br>YOUR INFORMATION | DRIVER'S LAST NAME  | FIRST NAME                    | MIDDLE NAME | DRIVER'S LICENSE NUMBER | STATE                | DATE OF BIRTH | GENDER<br><input type="radio"/> M <input type="radio"/> F <input type="radio"/> X |
|                               | DRIVER'S RESIDENCE ADDRESS  |                               |             | CITY                    | STATE                | ZIP CODE      | <input type="checkbox"/> CHECK BOX IF ADDRESS CHANGE                              |
|                               | MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)   |                               |             | CITY                    | STATE                | ZIP CODE      |   |
|                               | VEHICLE OWNER'S NAME AND ADDRESS<br><input type="checkbox"/> SAME<br><input type="checkbox"/> RENTAL? |                               |             | CITY                    | STATE                | ZIP CODE      |   |
|                               | INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS  |                               |             | CITY                    | STATE                | ZIP CODE      |   |
| POLICY NUMBER                 |   | VEHICLE IDENTIFICATION NUMBER |             | STATE                   | VEHICLE PLATE NUMBER | YEAR          | MAKE & MODEL  |

|           |  |  |
|-----------|--|--|
| SECTION 3 | Check all statements that apply:   | <input type="checkbox"/> Damage to your vehicle was more than \$2500.  |
|           |  | <input type="checkbox"/> Damage to any one person's property (other than vehicle) was more than \$2500.                                  |
|           |  | <input type="checkbox"/> Your vehicle was towed from the scene as a result of damages.   |
|           |  | <input type="checkbox"/> You or passengers in your vehicle were injured.   |
|           |  | <input type="checkbox"/> Collision with a parked vehicle.  |
|           |  | <input type="checkbox"/> The crash occurred while you were driving your employer's vehicle.  |
|           |  | <input type="checkbox"/> You were driving on your job and being paid for the principal purpose of driving.                               |
|           |  | <input type="checkbox"/> You were being paid to drive and/or deliver persons or property.  |
|           |  | <input type="checkbox"/> You were operating a government owned vehicle marked for transporting mail in accordance with government rules. |
|           |  | <input type="checkbox"/> You were operating an authorized emergency vehicle.   |
|           | <input type="checkbox"/> The crash occurred in a work or maintenance zone. ORS 811.230   |  |
|           | <input type="checkbox"/> A police officer came to the scene.   |  |
|           | Name of police department: _____ <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State Police |  |
|           | <input type="checkbox"/> You were operating a commercial motor vehicle requiring you to have a commercial driver license.            |  |
|           | <input type="checkbox"/> You were transporting hazardous material.   |  |
|           | <input type="checkbox"/> A citation was issued to you. The citation was: _____   |  |

|                               |   |                               |       |                      |   |
|-------------------------------|---|-------------------------------|-------|----------------------|---|
| SECTION 4<br>OTHER VEHICLE #2 | DRIVER'S NAME (LAST, FIRST, MIDDLE)                               | DRIVER'S LICENSE NUMBER       | STATE | DATE OF BIRTH        | GENDER<br><input type="radio"/> M <input type="radio"/> F <input type="radio"/> X |
|                               | DRIVER'S ADDRESS  | CITY                          | STATE | ZIP CODE             |   |
|                               | VEHICLE OWNER'S NAME AND ADDRESS<br><input type="checkbox"/> SAME | CITY                          | STATE | ZIP CODE             |   |
|                               | INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS                    |                               |       |                      |   |
|                               | POLICY NUMBER   | VEHICLE IDENTIFICATION NUMBER | STATE | VEHICLE PLATE NUMBER | YEAR  |

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE CRASH, USE ATTACHED SUPPLEMENTAL REPORT (Form 735-32B).

|           |   |
|-----------|---|
| SECTION 5 | DESCRIBE WHAT HAPPENED: (IF MORE SPACE IS NEEDED, SUBMIT ADDITIONAL PAGE) |
|           |   |

I certify all information given on this report is true and accurate to the best of my knowledge.

|   |  |                               |             |
|---|--|-------------------------------|-------------|
| SIGNATURE OF PERSON MAKING REPORT<br><b>X</b> | PRINTED NAME OF PERSON MAKING REPORT   | DAYTIME PHONE #<br>( )        | DATE SIGNED |
| IF NOT DRIVER'S SIGNATURE, STATE RELATIONSHIP | REASON DRIVER IS UNABLE TO SIGN REPORT | PHONE NUMBER OF DRIVER<br>( ) |             |

|   |  |   |   |
|---|--|---|---|
| <b>YOU INTENDED TO...</b><br><input type="checkbox"/> Go straight ahead<br><input type="checkbox"/> Make right turn<br><input type="checkbox"/> Make left turn<br><input type="checkbox"/> Make "U" turn<br><input type="checkbox"/> Back-Up<br><input type="checkbox"/> Enter driveway (also mark left or right turn)<br><input type="checkbox"/> Remain stopped in traffic<br><input type="checkbox"/> Enter parked position<br><input type="checkbox"/> Slow or Stop<br><input type="checkbox"/> Leave driveway (also mark left or right turn)<br><input type="checkbox"/> Start in traffic lane<br><input type="checkbox"/> Leave parked position<br><input type="checkbox"/> Remain parked<br><input type="checkbox"/> Overtake and pass | <b>YOUR VEHICLE</b><br><input type="checkbox"/> Passenger car, pickup, van<br><input type="checkbox"/> Military vehicle<br><input type="checkbox"/> Taxicab<br><input type="checkbox"/> Emergency vehicle<br><input type="checkbox"/> Any of the above and trailer<br><input type="checkbox"/> Private or public agency transit vehicle<br><input type="checkbox"/> Bus<br><input type="checkbox"/> School bus<br><input type="checkbox"/> Other publicly-owned veh.<br><input type="checkbox"/> Motorcycle<br><input type="checkbox"/> Motor Home / RV<br><input type="checkbox"/> Motor-scooter/bike<br><input type="checkbox"/> Personal (assisted) mobility device<br><input type="checkbox"/> Truck tractor & semi trailer<br><input type="checkbox"/> Truck/truck tractor<br><input type="checkbox"/> Other truck combination<br><input type="checkbox"/> Farm tractor/farm equip. | <b>WEATHER CONDITIONS</b><br><input type="checkbox"/> Clear<br><input type="checkbox"/> Raining<br><input type="checkbox"/> Snowing<br><input type="checkbox"/> Fog<br><input type="checkbox"/> Other<br><hr/> <b>ROAD SURFACE</b><br><input type="checkbox"/> Dry<br><input type="checkbox"/> Wet<br><input type="checkbox"/> Snowy<br><input type="checkbox"/> Icy<br><input type="checkbox"/> Other<br><hr/> <b>LIGHT CONDITIONS</b><br><input type="checkbox"/> Daylight<br><input type="checkbox"/> Dawn or dusk<br><input type="checkbox"/> Darkness (lighted)<br><input type="checkbox"/> Darkness (unlighted)<br><input type="checkbox"/> Other | <b>YOUR RESIDENCE</b><br><input type="checkbox"/> Local resident<br><small>(within 25 miles of crash site)</small><br><input type="checkbox"/> Residing elsewhere in state<br><input type="checkbox"/> Non-resident of this state:<br><input type="checkbox"/> College student<br><input type="checkbox"/> Military<br><input type="checkbox"/> Temporary job<br><hr/> <b>YOU WERE HEADED</b><br><input type="checkbox"/> North <input type="checkbox"/> East<br><input type="checkbox"/> South <input type="checkbox"/> West<br><br>On: _____<br><small>(name of street, road or route)</small><br><hr/> <b>OTHER DRIVER WAS HEADED</b><br><input type="checkbox"/> North <input type="checkbox"/> East<br><input type="checkbox"/> South <input type="checkbox"/> West<br><br>On: _____<br><small>(name of street, road or route)</small> |
|---|--|---|---|

**WITNESS INFORMATION:**

\_\_\_\_\_

\_\_\_\_\_

**If this crash involved a pedestrian or bicyclist, complete the following:**

PEDESTRIAN NAME     BICYCLIST NAME

Pedestrian or bicyclist was going:  
 N     S     E     W

ALONG OR ACROSS: (name of street, road or route)

From: \_\_\_\_\_

To: \_\_\_\_\_

EXAMPLE: (From: NE corner To: SE corner (or) From: East side To: West side, etc.)

**OCCUPANT INJURY AND SAFETY EQUIPMENT INFORMATION**

|  |   |
|--|---|
| <b>SAFETY EQUIPMENT CODES</b><br>WRITE one of the codes (0-10) in column C<br><br>0 No seat belt available<br>1 Seat belt available but NOT used<br>2 Seat belt available and in use<br>3 Child restraint device available but NOT used<br>4 Child restraint device in use<br>5 Child restraint device not available<br>6 Helmet NOT in use<br>7 Helmet in use<br>8 Air bag deployed<br>9 Air bag available - NOT deployed<br>10 Air bag NOT available | <b>INJURY CODE FOR OCCUPANTS</b><br>WRITE one of the codes (1-5) in column D<br><br>1 Fatal<br>2 Suspected Serious: severe laceration, broken or distorted limb, crush injury, significant burns, unconsciousness, paralysis<br>3 Suspected Minor: lump, abrasions, bruises, minor lacerations<br>4 Possible<br>5 No apparent |
|--|---|

| SEAT POSITION  | OCCUPANTS' NAMES (your vehicle) | A      |     | B        |         | C      |  | D |
|----------------|---------------------------------|--------|-----|----------|---------|--------|--|---|
|                |                                 | GENDER | AGE | SFTY EQP | AIR BAG | INJURY |  |   |
| DRIVER         |                                 |        |     |          |         |        |  |   |
| FRONT CENTER   |                                 |        |     |          |         |        |  |   |
| FRONT RIGHT    |                                 |        |     |          |         |        |  |   |
| MIDDLE* LEFT   |                                 |        |     |          |         |        |  |   |
| MIDDLE* CENTER |                                 |        |     |          |         |        |  |   |
| MIDDLE* RIGHT  |                                 |        |     |          |         |        |  |   |
| REAR LEFT      |                                 |        |     |          |         |        |  |   |
| REAR CENTER    |                                 |        |     |          |         |        |  |   |
| REAR RIGHT     |                                 |        |     |          |         |        |  |   |

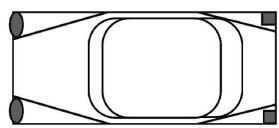
\* Use only for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

**Gender and age of pedestrian / bicyclist:**  
 M     F     X    Age: \_\_\_\_\_

**Extent of pedestrian / bicyclist injury:**  
 Fatal     Complaint of Pain  
 Suspected Serious     No apparent injury (or none noted)  
 Visible injury

**Pedestrian / bicyclist action: (mark one)**  
 Crossing at intersection or crosswalk  
 Crossing **not** at intersection or crosswalk  
 Walking / riding in roadway with traffic  
 Walking / riding in roadway **against** traffic  
 Standing in roadway  
 Pushing or working on vehicles in roadway  
 Other working in road  
 Playing in road  
 Hitchhiking  
 Not in roadway  
 Other \_\_\_\_\_ (specify)

**Vehicle Damage**



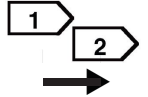
FRONT

USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)


Vehicle towed  
 Rollover  
 Under car  
 Totaled  
 Unknown


Your Vehicle (No. 1) damage: \$ \_\_\_\_\_ .


**Diagram**

Number each vehicle: 

Show path by: \_\_\_\_\_

Show pedestrian/bicyclist by: 

Show railroad tracks by: 

Show fixed object by: 

\_\_\_\_\_

\_\_\_\_\_

--- (name of street, road or route) ↑      --- (name of street, road or route) ↑

← (name of street, road or route)



# SUPPLEMENTAL REPORT OREGON TRAFFIC CRASH

**Supplemental for more than two drivers involved in the crash.  
Attach this form to your OREGON TRAFFIC CRASH AND INSURANCE REPORT.**

|  |                                   |                         |           |                                       |
|--|-----------------------------------|-------------------------|-----------|---------------------------------------|
| CRASH DATE   | DAY OF WEEK<br>M T W TH F<br>S SN | TIME OF DAY<br>AM<br>PM | COUNTY    | <b>DO NOT WRITE<br/>IN THIS SPACE</b> |
| ROAD ON WHICH CRASH OCCURRED (Name of street, road or route) |                                   |                         | MILE POST |                                       |

|  |                                     |  |
|--|-------------------------------------|--|
| <b>VEHICLE #3</b>                              | INSURANCE COMPANY NAME (NOT AGENCY) | POLICY NUMBER                          |
| VEHICLE IDENTIFICATION NUMBER                  | VEHICLE PLATE NUMBER                | STATE YEAR MAKE & MODEL                |
| OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER             | STATE DATE OF BIRTH GENDER<br>OM OF CX |
| DRIVER'S ADDRESS                               | CITY                                | STATE ZIP CODE                         |
| VEHICLE OWNER'S NAME AND ADDRESS               | CITY                                | STATE ZIP CODE                         |
| <input type="checkbox"/> SAME                  |                                     |  |

|  |                                     |  |
|--|-------------------------------------|--|
| <b>VEHICLE #4</b>                              | INSURANCE COMPANY NAME (NOT AGENCY) | POLICY NUMBER                          |
| VEHICLE IDENTIFICATION NUMBER                  | VEHICLE PLATE NUMBER                | STATE YEAR MAKE & MODEL                |
| OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER             | STATE DATE OF BIRTH GENDER<br>OM OF CX |
| DRIVER'S ADDRESS                               | CITY                                | STATE ZIP CODE                         |
| VEHICLE OWNER'S NAME AND ADDRESS               | CITY                                | STATE ZIP CODE                         |
| <input type="checkbox"/> SAME                  |                                     |  |

|  |                                     |  |
|--|-------------------------------------|--|
| <b>VEHICLE #5</b>                              | INSURANCE COMPANY NAME (NOT AGENCY) | POLICY NUMBER                          |
| VEHICLE IDENTIFICATION NUMBER                  | VEHICLE PLATE NUMBER                | STATE YEAR MAKE & MODEL                |
| OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER             | STATE DATE OF BIRTH GENDER<br>OM OF CX |
| DRIVER'S ADDRESS                               | CITY                                | STATE ZIP CODE                         |
| VEHICLE OWNER'S NAME AND ADDRESS               | CITY                                | STATE ZIP CODE                         |
| <input type="checkbox"/> SAME                  |                                     |  |

|  |                                     |  |
|--|-------------------------------------|--|
| <b>VEHICLE #6</b>                              | INSURANCE COMPANY NAME (NOT AGENCY) | POLICY NUMBER                          |
| VEHICLE IDENTIFICATION NUMBER                  | VEHICLE PLATE NUMBER                | STATE YEAR MAKE & MODEL                |
| OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER             | STATE DATE OF BIRTH GENDER<br>OM OF CX |
| DRIVER'S ADDRESS                               | CITY                                | STATE ZIP CODE                         |
| VEHICLE OWNER'S NAME AND ADDRESS               | CITY                                | STATE ZIP CODE                         |
| <input type="checkbox"/> SAME                  |                                     |  |

|  |                                     |  |
|--|-------------------------------------|--|
| <b>VEHICLE #7</b>                              | INSURANCE COMPANY NAME (NOT AGENCY) | POLICY NUMBER                          |
| VEHICLE IDENTIFICATION NUMBER                  | VEHICLE PLATE NUMBER                | STATE YEAR MAKE & MODEL                |
| OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE) | DRIVER'S LICENSE NUMBER             | STATE DATE OF BIRTH GENDER<br>OM OF CX |
| DRIVER'S ADDRESS                               | CITY                                | STATE ZIP CODE                         |
| VEHICLE OWNER'S NAME AND ADDRESS               | CITY                                | STATE ZIP CODE                         |
| <input type="checkbox"/> SAME                  |                                     |  |

# MOTOR CARRIER CRASH REPORT

(For CMV Drivers Only)

**INSTRUCTIONS: IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN AND A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE MOTOR CARRIER CRASH REPORT AND SUBMIT TO THE ADDRESS SHOWN ABOVE. IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER CRASH REPORT, PLEASE CALL (503) 986-3507. [www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/](http://www.oregontruckingonline.com/cf/MCAD/pubMetaEntry/accidentRpt/)**

|   |  |  |                       |
|---|--|--|-----------------------|
| <b>QUALIFYING VEHICLE</b>   |  | <b>CRITERIA</b>  |                       |
| <input type="checkbox"/> COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF CRASH EVEN IF GVWR IS SET UNDER 10,000 LBS )<br><input type="checkbox"/> HAZARDOUS MATERIAL PLACARD<br><input type="checkbox"/> COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS)<br><input type="checkbox"/> FARM TRUCK INTERSTATE (OVER 10,000 LBS.)<br><input type="checkbox"/> FARM TRUCK FOR-HIRE (4 OR MORE AXLES)<br><input type="checkbox"/> FARM TRUCK TOWING TRIPLE TRAILERS<br><input type="checkbox"/> FARM TRUCK (OVER 80,000 LBS.) |  | <input type="checkbox"/> ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE CRASH)<br><input type="checkbox"/> ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE<br><input type="checkbox"/> ANY VEHICLE INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE |                       |
| MOTOR CARRIER NAME  |  | US DOT NUMBER  | AUTHORITY/FILE NUMBER |
| ADDRESS   |  | CITY   | STATE      ZIP CODE   |

**DRIVER INFORMATION**

|                                   |       |   |   |
|-----------------------------------|-------|---|---|
| DRIVER NAME (LAST, FIRST, MIDDLE) |       | DATE OF BIRTH   | LENGTH OF EMPLOYMENT<br>YEARS      MONTHS |
| CDL / DL NUMBER                   | STATE | LICENSE CLASS<br><input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> M | EXPIRATION DATE OF MEDICAL CERTIFICATE    |

COMPLETE THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF THE CRASH.

|  |  |  |
|--|--|--|
| AT TIME OF THE CRASH, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD. _____                        | TOTAL HOURS ON DUTY DURING THE PREVIOUS (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS) | 7 CONSECUTIVE DAYS _____<br>8 CONSECUTIVE DAYS _____ |
| DOES YOUR DRIVER HAVE A MEDICAL WAIVER<br><input type="checkbox"/> YES <input type="checkbox"/> NO | TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)                                      |  |

**DRIVER INJURY INFORMATION**

|  |   |  |   |  |
|--|---|--|---|--|
| YOUR DRIVER KILLED<br><input type="checkbox"/> YES <input type="checkbox"/> NO | YOUR DRIVER INJURED<br><input type="checkbox"/> YES <input type="checkbox"/> NO | RELIEF DRIVER KILLED<br><input type="checkbox"/> YES <input type="checkbox"/> NO | RELIEF DRIVER INJURED<br><input type="checkbox"/> YES <input type="checkbox"/> NO | TOTAL NUMBER OF PASSENGERS<br>____ KILLED   ____ INJURED |
|--|---|--|---|--|

**OTHER DRIVER INJURY INFORMATION**

|   |  |   |  |
|---|--|---|--|
| TOTAL NUMBER OF OTHER DRIVERS<br>____ KILLED   ____ INJURED | TOTAL NUMBER OF OTHER PASSENGERS<br>____ KILLED   ____ INJURED | TOTAL NUMBER OF PEDESTRIANS<br>____ KILLED   ____ INJURED | TOTAL NUMBER OF BICYCLISTS<br>____ KILLED   ____ INJURED |
|---|--|---|--|




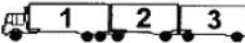
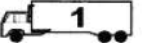




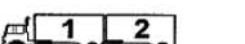

**OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)**

| MOTOR CARRIER NAME | VEHICLE LICENSE # AND STATE | DRIVER'S NAME | DRIVER'S LICENSE # AND STATE |
|--------------------|-----------------------------|---------------|------------------------------|
|                    |                             |               |                              |
|                    |                             |               |                              |
|                    |                             |               |                              |

**MOTOR CARRIER VEHICLE INFORMATION**

|      |      |             |   |                                       |
|------|------|-------------|---|---------------------------------------|
| YEAR | MAKE | UNIT NUMBER | LICENSE PLATE # & STATE - TRUCK/TRACTOR/BUS | TOTAL NO. OF AXLES INCLUDING TRAILERS |
|      |      |             |   |                                       |

**TRACTOR TYPE (SELECT APPROPRIATE TYPE)**

|  |  |  |
|--|--|--|
| <input type="checkbox"/> 1  Triples (tractor with 3 trailers) | <input type="checkbox"/> 5  Standard Tractor/Semi Trailer | <input type="checkbox"/> 9  Heavy Haul                              |
| <input type="checkbox"/> 2  Triples (truck with 2 trailers)   | <input type="checkbox"/> 6  Straight Truck                | <input type="checkbox"/> 10  Bus/Van (8 or more passenger capacity) |
| <input type="checkbox"/> 3  Straight truck-full trailer       | <input type="checkbox"/> 7  Auto/Tractor                  | <input type="checkbox"/> 11  Auto/Pickup                            |
| <input type="checkbox"/> 4  Doubles (any)                     | <input type="checkbox"/> 8  Saddlemount                   |  |

**TRAILER TYPE (CHECK ONE)**

- VAN FLATBED TANKER CONTAINER POLE/LOG DUMP BELLY-DUMP CAR CARRIER LIVESTOCK  
MOBILE HOME TOWER PASSENGER DROP-BOX GARBAGE BULK-HOPPER MIXER SADDLEMOUNT  
WRECKER FIXED LOAD HEAVY HAUL UTILITY

**COMMODITY INFORMATION**

COMMODITY BEING TRANSPORTED AT TIME OF CRASH

 WAS A HAZARDOUS COMMODITY BEING HAULED  
 YES  NO

 WAS HAZARDOUS MATERIAL RELEASED FROM  
 THE VEHICLE CARGO (NOT A FUEL RELEASE)  YES  NO

HAZARD CLASS

**CRASH INFORMATION**

LOCATION OF CRASH (NEAREST CITY OR TOWN)

HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD

DIRECTION OF YOUR VEHICLE (CHECK)

N S E W

DATE OF CRASH

TIME

 AM  
 PM

DAY OF THE WEEK (CHECK ONE)

MON TUES WED THU FRI SAT SUN
**CONDITIONS AT TIME OF CRASH**
 WEATHER (CHECK ONE) 1. CLEAR 2. RAIN 3. SNOW 4. CLOUDY 5. SLEET 6. FOG 7. OTHER \_\_\_\_\_

 ROAD SURFACE (CHECK ONE) 1. DRY 2. WET 3. SNOWY 4. ICY 5. OTHER \_\_\_\_\_

 LIGHT CONDITION (CHECK ONE) 1. DAY 2. DAWN 3. DUSK 4. ARTIFICIAL LIGHTS 5. DARK 6. OTHER \_\_\_\_\_

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. YOUR VEHICLE IS ALWAYS NO.1. IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 &amp; 3 TO CORRESPOND TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

| VEHICLES<br>1 2 3 | ACTION  | VEHICLES<br>1 2 3 | ACTION                   | VEHICLES<br>1 2 3 | ACTION                       |
|-------------------|---|-------------------|--------------------------|-------------------|------------------------------|
|                   | SLOWING - STOPPING  |                   | PASSING                  |                   | JACKKNIFE                    |
|                   | STOPPED   |                   | CHANGING LANES           |                   | OVERTURN                     |
|                   | REAR-END  |                   | SIDESWIPE                |                   | SEPARATION OF UNITS          |
|                   | BACKING   |                   | HEAD-ON                  |                   | FIRE                         |
|                   | MAKING RIGHT TURN   |                   | SKIDDING                 |                   | EXPLOSION                    |
|                   | MAKING LEFT TURN  |                   | VEHICLE OUT OF CONTROL   |                   | CARGO SHIFT                  |
|                   | MAKING U TURN   |                   | ROLL-AWAY                |                   | CARGO SPILL (HAZARDOUS)      |
|                   | PROCEEDING STRAIGHT   |                   | CONTROLLED RR CROSSING   |                   | CARGO SPILL (NON-HAZARDOUS)  |
|                   | INTERSECTION  |                   | UNCONTROLLED RR CROSSING |                   | OTHER (DEER, GUARDRAIL, ETC) |
|                   | ENTERING TRAFFIC (FROM SHOULDER,<br>MEDIAN, PARKING STRIP OR PRIVATE DRIVE) |                   | RAN OFF ROAD             |                   | _____                        |

 DID YOUR VEHICLE STRIKE A PARKED VEHICLE  
 YES  NO

 WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE  
 YES  NO
**DESCRIPTION OF CRASH (BY CARRIER OR DRIVER)**

|  |
|--|
|  |
|  |
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|  |
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|  |
|  |

NAME AND TITLE OF PERSON SIGNING REPORT

TELEPHONE NUMBER(S)

SIGNATURE I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE

DATE

X