

Wisconsin DRIVER REPORT OF ACCIDENT

DO NOT COMPLETE this Driver Report of Accident if a law enforcement officer completed a Wisconsin Motor Vehicle Accident Report.

COMPLETE this Wisconsin Driver Report of Accident if:

- There was \$1000 or more damage to any one person's property
- OR -
- Anyone was injured
- OR -
- There was \$200 or more damage to government property, other than vehicles.

MV4002 1/2004 s.346.70(2) Wis. Stats.

Wisconsin Department of Transportation

Please provide all requested information. Print clearly.

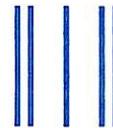
1. You are "Unit 1".
2. An individual involved in the accident must sign the report.
3. Provide all information on the other driver(s)/owner(s) involved. Incomplete reports may be returned requesting missing information. If you need assistance, contact your insurance agent, local law enforcement agency, or the DOT Traffic Accident Section at 608-266-8753.
4. Use the "Narrative" and "Diagram" sections to explain how the accident happened.
5. If more space is needed, use plain paper and attach to this report.
6. This form is available at www.dot.wisconsin.gov/drivers/drivers/traffic/accident.htm.

Retain a copy of this report for your records before mailing.

Mail completed report to address shown below.

(Fold report so that address panel shows to outside - tape bottom edge closed and mail - Do not staple).

Important - Please print your return address:



Place stamp here
Post Office
will not deliver
without postage

**TRAFFIC ACCIDENT SECTION
WISCONSIN DEPT OF TRANSPORTATION
P O BOX 7919
MADISON WI 53707-7919**



WISCONSIN DRIVER REPORT OF ACCIDENT

(See instructions on reverse side
before completing - Please Print!)

**CONTINUE ONLY ...if there was \$1000 or more damage to any one person's property,
OR ...if anyone was injured,
OR ...if there was \$200 or more damage to government property, other than vehicles.**

<input type="checkbox"/> YES	ACCIDENT LOCATION	County of _____	City, Village or Township of _____	ACCIDENT DATE	Month _____	Day _____	Year _____	Day of Week _____	Time <input type="checkbox"/> AM <input type="checkbox"/> PM
Total Units Involved _____	Total Injured * _____	Name and Number of Street(s) or Highway or Parking Lot _____							

TYPE OF ACCIDENT (Please check one) 1 Hit another motor vehicle in operation 2 Hit a parked vehicle 3 Hit a deer 4.5 Hit a bicyclist or pedestrian 9 Other

<p>U N I T 1</p> <p>Driver Full Name (Last, First, MI) _____ Sex _____</p> <p>Address _____ Birth Date _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>Driver License Number _____ Issuing State _____</p> <p>Vehicle Legally Parked <input type="checkbox"/> YES <input type="checkbox"/> NO Operating a commercial vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, circle appropriate classification A B C</p> <p>Owner Full Name (Last, First, MI) _____</p> <p>Address _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>License Plate Number _____ Exp Yr _____ Issuing State _____ Vehicle Make _____ Year _____ Color _____</p> <p>Vehicle Identification Number _____</p> <p>Was a motor vehicle liability insurance policy in effect on the day of the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES Policy Holder's Name _____</p> <p>Exact Name of Insurance Company _____</p>	<p>U N I T 2</p> <p>Driver Full Name (Last, First, MI) _____ Sex _____</p> <p>Address _____ Birth Date _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>Driver License Number _____ Issuing State _____</p> <p>Vehicle Legally Parked <input type="checkbox"/> YES <input type="checkbox"/> NO Operating a commercial vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, circle appropriate classification A B C</p> <p>Owner Full Name (Last, First, MI) _____</p> <p>Address _____</p> <p>City & State _____ Zip Code _____ Daytime Phone Number () _____</p> <p>License Plate Number _____ Exp Yr _____ Issuing State _____ Vehicle Make _____ Year _____ Color _____</p> <p>Vehicle Identification Number _____</p> <p>Was a motor vehicle liability insurance policy in effect on the day of the accident? <input type="checkbox"/> NO <input type="checkbox"/> YES Policy Holder's Name _____</p> <p>Exact Name of Insurance Company _____</p>
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***INJURED Important** - Number of injuries reported must equal number entered in "Total Injured" box above. For additional injuries, provide the information on a separate piece of paper and attach. **Injury Codes: A=Severe, B=Moderate, C=Minor**

Unit No.	Name (Last, First, MI)	Address	City & State	Zip Code	Sex	Birth Date	Injury Code

VEHICLE DAMAGE Unit 1 - Important - Circle the numbers closest to the damaged areas.

Damage Estimate (Required) \$ _____

Unit 2 - Important - Circle the numbers closest to the damaged areas.

Damage Estimate (If Known) \$ _____

PROPERTY DAMAGE Describe what was damaged. Property damage includes structures, trees, fences, towed items, etc. Do NOT include vehicle damage.

Property Owner Full Name (Last, First, MI) _____	Address, City, State & Zip Code _____	Daytime Phone Number () _____
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NARRATIVE Print a brief description of the accident.

DIAGRAM Draw a basic picture of the accident and location. Indicate North by putting an arrow in the circle.

X _____
(Signature Required)