

NEW JERSEY MOTOR VEHICLE COMMISSION
MOTOR VEHICLE ACCIDENT REPORT

Follow Instructions
on other side

14 ACCIDENT DATE 15 DAY OF WK. 16 TIME AM PM 17 NUMBER OF VEHICLES KILLED 18 NUMBER OF VEHICLES INJURED 19 NUMBER INJURED 20 DID POLICE INVESTIGATE ACCIDENT? YES NO 21 NAME OF POLICE AGENCY

22 LOCATION OF ACCIDENT (MUNICIPALITY) 23 ROUTE NUMBER OR NAME OF STREET 24 IF NOT AT INTERSECTION COLLISION WAS BETWEEN:
ROAD 1 _____
ROAD 2 _____
DISTANCE FROM ROAD 1 _____

25 COUNTY 26 INTERSECTING STREET, ROAD OR RAILROAD

27 INSURANCE COMPANY 44 INSURANCE COMPANY

Your Vehicle No. 1 28 POLICY NO. 45 POLICY NO.

29 DRIVER'S FIRST NAME LAST NAME INITIAL LAST NAME
46 DRIVER'S FIRST NAME INITIAL LAST NAME

30 NUMBER AND STREET 47 NUMBER AND STREET

31 CITY STATE ZIP CODE 48 CITY STATE ZIP CODE

32 DRIVERS LICENSE NUMBER 33 STATE 34 BIRTHDATE 35 EYE COLOR 36 SEX 49 DRIVERS LICENSE NUMBER 50 STATE 51 BIRTHDATE 52 EYE COLOR 53 SEX

37 OWNER'S FIRST NAME LAST NAME INITIAL LAST NAME
54 OWNER'S FIRST NAME SAME AS DRIVER 55 NUMBER AND STREET

38 NUMBER AND STREET 56 CITY STATE ZIP CODE

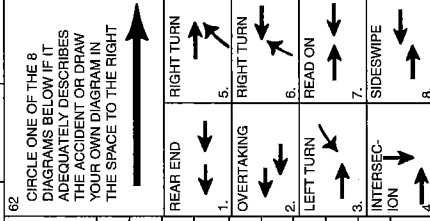
40 MAKE OF VEHICLE 41 YEAR 42 LICENSE PLATE NO. 43 STATE 44 MAKE OF VEHICLE 45 YEAR 46 LICENSE PLATE NO. 47 STATE

61 DESCRIBE DAMAGE TO VEH. NO. 1 62 CIRCLE ONE OF THE 8 DIAGRAMS BELOW IF IT ADEQUATELY DESCRIBES THE ACCIDENT OR DRAW YOUR OWN DIAGRAM IN THE SPACE TO THE RIGHT

63 9

64 DESCRIBE DAMAGE TO VEH. NO. 2

EST. COST TO REPAIR 65 ACCIDENT DESCRIPTION



INJURED LOCATED
1 IN VEH. 1 B ON A PEDALCYCLE 0 OTHER
2 IN VEH. 2 P PEDESTRIAN

POSITION IN/ON VEHICLE
1 DRIVER 2 THRU 7 PASSENGERS
8 RIDING/HANGING ON OUTSIDE

67 68 69

VICTIM'S PHYSICAL CONDITION
1 KILLED
2 INCAPACITATED
3 MODERATE INJURY
4 COMPLAINT OF PAIN

66 DESCRIBE DAMAGE TO PROPERTY OTHER THAN VEHICLE (GIVE OWNER'S NAME AND ADDRESS AND EST. COST TO REPAIR)

Injury Section: Fill Out Space Below for Every Person Injured or Killed in the Accident.

70 AGE	71 SEX	NAME AND ADDRESS OF INJURED
		NATURE OF INJURY
		NAME AND ADDRESS OF INJURED
		NATURE OF INJURY

SIGN HERE **Date of Report**

NEW JERSEY SR-21

Fill in this form with information from your insurance policy. All information will be verified with the insurance company.

NAME OF INSURANCE COMPANY COVERING YOU FOR LIABILITY FOR DAMAGE OR INJURY TO OTHERS (NOT AGENT)

NAME AND ADDRESS OF INSURANCE AGENT WHO SOLD YOU POLICY

POLICY NO. _____ FROM _____ TO _____

DATE OF ACCIDENT MONTH DAY YEAR MAKE OF YOUR VEHICLE (NO. 1) YEAR VEHICLE IDENTIFICATION NO.

LOCATION OF ACCIDENT - STREET OR ROUTE NO. AND MUNICIPALITY (SAME AS ITEMS 23, 24 ABOVE)

NAME AND ADDRESS OF DRIVER - VEHICLE 1

NAME AND ADDRESS OF OWNER - VEHICLE 1

NAME AND ADDRESS OF POLICY HOLDER - VEHICLE 1

IMPORTANT - This accident should also be reported directly to your Insurance representative. Failure to report may jeopardize your vehicle liability insurance.

SECTION A

Report of Accidents. The driver of a vehicle involved in an accident resulting in injury to or death of any person, or damage to property of any one person in excess of five hundred dollars (\$500) shall within ten days after such accident forward a written report of such accident TO: NJ DEPARTMENT OF TRANSPORTATION, 1035 PARKWAY AVENUE, P. O. BOX 600, TRENTON, NJ 08625-0600 ATTN: BUREAU OF SAFETY PROGRAMS, THIOKOL BLDG. #8. Failure to report will result in the suspension of both driving and registration privileges. Under Chapter 4 of Title 39 these reports are not available for public information nor are they admissible in evidence for any other purpose in a proceeding or action arising out of the accident. They are solely for the use of the Department of Transportation in developing information useful in the prevention of accidents and for compliance with the Motor Vehicle Security Responsibility and Compulsory Insurance Laws. "A written report of an accident shall not be required if a law enforcement officer submits a written report of the accident to the division pursuant to R.S. 39:4-131."

INSTRUCTIONS PLEASE PRINT OR TYPE ALL INFORMATION USE BLACK OR DARK BLUE INK

Begin by folding along this line
Follow the instructions at the top of Section B.
Numbered arrows should point to
boxes on reverse side after folding.

1. Give exact date of accident.
2. If a vehicle is unoccupied, enter all available information. Be sure to enter the correct vehicle plate number.
3. Driver information must be entered exactly as it appears on each driver's license.
4. Owner information must be entered exactly as it appears on the registration certificate of each vehicle involved in the accident.
5. If you were involved in an accident in which there were more than two vehicles, an additional one of these report forms must be filled out. On that form, place the information for the third vehicle in the space marked "Your Vehicle No. 1" and mark it No. 3. Use the space marked "Other Vehicle No. 2" for the fourth vehicle, and mark it No. 4 and so on.
6. The location of the accident is very important and you should describe it as accurately as possible in the space provided.
7. For each person injured complete boxes 67, 68, 69, 70, 71 and list names and addresses.
8. If there are more than two persons injured, another one of these report forms is needed. In the injury section of that report, record the required information for all additional injured persons.
9. Attach any additional report forms to page one. Each page of the report must be numbered in the upper right corner, dated and SIGNED on the bottom line.
10. Answer all questions to the best of your knowledge.
11. Send all reports to:

NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
P. O. BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF SAFETY PROGRAMS
THIOKOL BLDG. #8

DO NOT FILL IN

FOR USE OF INSURANCE COMPANY ONLY Instructions for Insurance Company

With regard to an automobile liability insurance policy for the policyholder named on the reverse side hereof, the undersigned insurance company advises you in accordance with the items checked below:

1. No policy was in effect on the date of the accident.
 2. Our policy for the named policyholder applies to him as the operator but it does not apply to the owner of the vehicle involved in the accident.
 3. Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident.
 4. Other; explain.

NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
P. O. BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF SAFETY PROGRAMS
THIOKOL BLDG. #8

Name of Insurance Company

MUST be signed by Authorized Representatives

SECTION B

REPORT OF MOTOR VEHICLE ACCIDENT

Be sure form is folded along this line before answering the questions below.

Numbered arrows should point to boxes on reverse side after folding.

Fill in the 13 boxes to the right by entering the number of the item which best describes the circumstances of the accident.

If a question does not apply enter a dash (—).
If an answer is unknown enter a "U".

FOLD ALONG THIS LINE

1 DRY 2 WET 3 SNOWY 4 ICE 5 OTHER	1 DAYLIGHT 2 DAWN OR DUSK 3 DARK (ST LIGHT ON) 4 DARK (ST LIGHT OFF) 5 DARK (NO ST LIGHTS)	1 CLEAR 2 RAIN 3 SNOW 4 FOG 5 OTHER	DIRECTION OF TRAVEL 1 NORTH 2 SOUTH 3 EAST 4 WEST		YOUR VEHICLE NO. 1	VEHICLE NO. 2
SURFACE CONDITION		WEATHER		YOUR VEHICLE NO. 1		YOUR VEHICLE NO. 1
LIGHT CONDITION		DIRECTION OF TRAVEL		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2
VEHICLE TYPE		VEHICLE TYPE		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2
COLLISION INVOLVED		COLLISION INVOLVED		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2
LOCATION OF FIRST EVENT		LOCATION OF FIRST EVENT		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2
VEHICLE POSITION		VEHICLE POSITION		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2
DRIVER EMPLOYMENT		DRIVER EMPLOYMENT		YOUR VEHICLE NO. 1		OTHER VEHICLE NO. 2

Please Read Instructions 1 Through 11 On other Side of Fold Before Completing The inside of Report.