

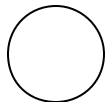
ARKANSAS MOTOR VEHICLE COLLISION REPORT

Report # _____		Unit Assigned _____		Premises _____		Geo Code _____		District _____	
Mo/Day/Yr	Day of Week	Time Of Collision	No. Of Vehicles	Time Notified	Time Arrived	Hit & Run <input type="checkbox"/> Yes <input type="checkbox"/> No	Direction Of Travel V# _____ V# _____		Official Use Only
		<input type="checkbox"/> AM <input type="checkbox"/> PM		<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM				
County		City		Not In City, But _____ Of _____		Speed Limit			
				Distance	Direction	City Limits			
Road / Street / Highway			Section	Log Mile	At Intersection With			Posted <input type="checkbox"/> Yes <input type="checkbox"/> No	
Not At Intersection, But _____				Reference Point					
				<input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W					
				Distance					

VEHICLE # _____ (PEDESTRIAN # _____)					VEHICLE # _____ (PEDESTRIAN # _____)				
Commercial Vehicle Supplement Required? <input type="checkbox"/> Yes <input type="checkbox"/> No					Commercial Vehicle Supplement Required? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Driver's Name (First/MI/Last Name)			Inj. Code		Driver's Name (First/MI/Last Name)			Inj. Code	
Address		Safety Equip.	Eject Code		Address		Safety Equip.	Eject Code	
City		State	Zip Code		City		State	Zip Code	
Additional Information					Additional Information				
DOB	Race	Sex	Driver's License State	Class	DOB	Race	Sex	Driver's License State	Class
			# _____	End. _____				# _____	End. _____
Blood/Breath/Urine Test Requested			Results (If Known)		Blood/Breath/Urine Test Requested			Results (If Known)	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No				
Vehicle Owner's Name (First/MI/Last Name)					Vehicle Owner's Name (First/MI/Last Name)				
Address					Address				
City		State	Zip Code		City		State	Zip Code	
Vehicle Description		Year	Make		Vehicle Description		Year	Make	
Model		Body Style	Color		Model		Body Style	Color	
Vehicle Identification Number			Estimated Damage		Vehicle Identification Number			Estimated Damage	
Vehicle License Plate			<input type="checkbox"/> None		Vehicle License Plate			<input type="checkbox"/> None	
Year		State	Number		Year		State	Number	
Trailers	# Of Units	Reg. State	Plate #		Trailers	# Of Units	Reg. State	Plate #	
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No				
Prior Vehicle Damage? If Yes, Describe Damage & Location					Prior Vehicle Damage? If Yes, Describe Damage & Location				
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No				
Vehicle Damage As Result Of Collision					Vehicle Damage As Result Of Collision				
<input type="checkbox"/> Disabled <input type="checkbox"/> Other Damage <input type="checkbox"/> Functional <input type="checkbox"/> No Damage					<input type="checkbox"/> Disabled <input type="checkbox"/> Other Damage <input type="checkbox"/> Functional <input type="checkbox"/> No Damage				
Towed?		Name Of Tow Service			Towed?		Name Of Tow Service		
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No				
Address Vehicle Removed To					Address Vehicle Removed To				
City		State	Zip Code		City		State	Zip Code	
Additional Information					Additional Information				
Insurance Company			Policy #		Insurance Company			Policy #	
EMS Notified		<input type="checkbox"/> AM <input type="checkbox"/> PM	Transported By		EMS Notified		<input type="checkbox"/> AM <input type="checkbox"/> PM	Transported By	
EMS Arrived		<input type="checkbox"/> AM <input type="checkbox"/> PM			EMS Arrived		<input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> No Injury/Transport					<input type="checkbox"/> No Injury/Transport				
Injured Transported To (Hospital Name/City/State)					Injured Transported To (Hospital Name/City/State)				

Diagram

SAMPLE



Indicate North By Arrow

ARKANSAS COMMERCIAL MOTOR VEHICLE COLLISION REPORT SUPPLEMENT

Page ____ of ____

Report # _____

Requirements For Use Of Commercial Motor Vehicle Supplement

A Commercial Motor Vehicle Supplement is **required** to be completed when the collision involves:

- A motor vehicle with a gross vehicle weight rating or a combination gross vehicle rating in excess of 10,000 pounds that is being used on a public highway to carry property; or
- A motor vehicle displaying a hazardous material placard; or
- A motor vehicle that is designed to transport 7 or more people including the driver;

AND

- The collision results in injury which requires the transportation of the injured person to a medical facility; or
- The collision results in a fatality; or
- Any vehicle involved in the collision is towed from the scene.

Gross Vehicle Rating

- 10,001 To 26,000 Pounds More Than 26,000 Pounds

Carrier's Identification Number

U.S. Dot # _____

ICC MC # _____

Carrier's Information

Name: _____

Address: _____

City: _____ State _____ Zip _____

Interstate Carrier? Yes No

Sequence Of Events

1. Ran Off Roadway
2. Jackknife
3. Overturn (Rollover)
4. Downhill Runaway
5. Cargo Loss/Shift
6. Explosion/ Fire
7. Separation Of Units
8. Collision Involving Pedestrians
9. Collision With A Motor Vehicle In Transport
10. Collision With Parked Motor Vehicle
11. Collision With Train
12. Collision With Pedacycle
13. Collision With Animal
14. Collision With Fixed Object
15. Collision With Other Object
16. Collision With Work Zone Maintenance Equipment
17. Collision With Other Moveable Object
18. Collision With Unknown Moveable Object
19. Non-Collision
20. Non-Collision Equipment Failure
21. Non-Collision Other
22. Non-Collision Unknown
23. Other

1st 2nd 3rd 4th

Hazardous Material

Did Vehicle Have A Haz Mat Placard? Yes No

Was There Hazardous Material Leakage? (Don't Count Fuel From Fuel Tank) Yes No

If The Vehicle Has A Placard Indicate The Following:

4-Digit Placard Number 1-Digit Number From
From Diamond Box Bottom Of Diamond

- Cargo Body Type**
- 1A. Bus (Designated To Transport 7-15 People)
 - 1B. Bus (Designated To Transport 16 Or More People)
 2. Van/Enclosed Box
 3. Cargo Tank
 4. Flatbed
 5. Dump
 6. Concrete Mixer
 7. Auto Transporter
 8. Garbage/Refuse
 9. Grain/Chips/Gravel
 10. Pole
 11. Not Applicable

- Vehicle Configuration**
- 1A. Bus (Seats 7 + People Including Driver)
 - 1B. Bus (Seats 16 + People Including Driver)
 2. Single Truck 2 Axle 6 Tires
 3. Single Truck 3 Or More Axles
 4. Truck/Trailer
 5. Truck Tractor (Bobtail)
 6. Tractor/Semi-Trailer
 7. Tractor/Doubles
 8. Tractor/Triples
 9. Passenger Car (Haz Mat)
 10. Light Truck (Haz Mat)
 11. Unknown Heavy Truck