



# SPRINGFIELD POLICE DEPARTMENT

321 E. Chestnut Expressway, Springfield MO 65802

## WALK-IN ACCIDENT REPORT



OFFICE USE ONLY	
Case #:	Beat:
Date of Accident Report:	Time of Accident Report:
# Of Vehicles Involved:	# Of Persons Injured:
Leaving the Scene	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Property Damage Only	<input type="checkbox"/> Vehicle # 1 <input type="checkbox"/> Vehicle # 2

Date of Accident:	Time of Accident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
If Accident was on a parking lot, Name of Business:	
Location of Accident: (Must be within City limits of Springfield MO)	

### DRIVER VEHICLE #1 INFORMATION (YOU)

Driver's Name:	Driver's License Number:	Driver's Date of Birth:
Driver's Street Address:	City:	State: Zip: Phone #:

### VEHICLE/OWNER INFORMATION VEHICLE #1 (YOU)

Vehicle Information			Damage		Vehicle Owner Information <input type="checkbox"/> Same as Driver #1 Information		
Year:	Make:	Model:	Circle All Areas Of Damage Front [ ] VEH [ ] Rear	Vehicle Owner's Name:	Phone #:		
Color:	License Plate #:	State:		Vehicle Owner's Street Address:			
Insurance Company:				City:	State:	Zip:	

### DRIVER VEHICLE #2 INFORMATION

Driver's Name:	Driver's License Number:	Driver's Date of Birth:
Driver's Street Address:	City:	State: Zip: Phone #:

### VEHICLE/OWNER INFORMATION VEHICLE #2

Vehicle Information			Damage		Vehicle Owner Information <input type="checkbox"/> Same as Driver #2 Information		
Year:	Make:	Model:	Circle All Areas Of Damage Front [ ] VEH [ ] Rear	Vehicle Owner's Name:	Phone #:		
Color:	License Plate #:	State:		Vehicle Owner's Street Address:			
Insurance Company:				City:	State:	Zip:	

### INVOLVEMENT OF OTHER PERSONS

Type	Name	Address	City	State	Zip	Phone #	Extent of Injuries
<input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Witness							
<input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Witness							
<input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Witness							

### DAMAGE TO PROPERTY OTHER THAN VEHICLES


Property Owner's Name	Address	City	State	Zip	Phone #	Extent of Damage

**ACCIDENT INFORMATION**

<p><b>Collision Involving</b></p> <input type="checkbox"/> 1. Animal <input type="checkbox"/> 2. Bicyclist <input type="checkbox"/> 3. Fixed Object <input type="checkbox"/> 4. Pedestrian <input type="checkbox"/> 5. MV in Transport* <input type="checkbox"/> 6. Parked Vehicle* <p>*If 5 or 6 are checked please mark one box below:</p> <input type="checkbox"/> Head On <input type="checkbox"/> Rear End <input type="checkbox"/> Sideswipe-Meeting <input type="checkbox"/> Sideswipe-Passing <input type="checkbox"/> Angle <input type="checkbox"/> Backed Into <input type="checkbox"/> Other	<p><b>Your Vehicle's Actions</b></p> <p>Please enter your vehicle's action(s) from the first event to its final rest in the space provided:</p> <p align="center">_____/_____/_____</p> <ol style="list-style-type: none"> <li>1. Going Straight</li> <li>2. Overturning</li> <li>3. Making Right Turn</li> <li>4. Right Turn on Red</li> <li>5. Making Left Turn</li> <li>6. Making U Turn</li> <li>7. Skidding/Sliding</li> <li>8. Slowing/Stopping</li> <li>9. Start in Traffic</li> <li>10. Start From Parked</li> <li>11. Backing</li> <li>12. Stopped in Traffic</li> <li>13. Parked</li> </ol>	<p><b>Traffic Control</b></p> <p>You V1 V2</p> <input type="checkbox"/> <input type="checkbox"/> Stop Sign <input type="checkbox"/> <input type="checkbox"/> Elec. Signal <input type="checkbox"/> <input type="checkbox"/> RR Signal/Gate <input type="checkbox"/> <input type="checkbox"/> Yield Sign <input type="checkbox"/> <input type="checkbox"/> Officer/Flagman <input type="checkbox"/> <input type="checkbox"/> No Passing Zone <input type="checkbox"/> <input type="checkbox"/> Turn Restricted <input type="checkbox"/> <input type="checkbox"/> Construction Zone <input type="checkbox"/> <input type="checkbox"/> School Zone Signal <input type="checkbox"/> <input type="checkbox"/> None	<p><b>Vision Obstructed</b></p> <p>You V1</p> <input type="checkbox"/> Windshield <input type="checkbox"/> Load on Vehicle <input type="checkbox"/> Trees/Brush <input type="checkbox"/> Building <input type="checkbox"/> Embankment <input type="checkbox"/> Signboards <input type="checkbox"/> Hillcrest <input type="checkbox"/> Parked Cars <input type="checkbox"/> Moving Cars <input type="checkbox"/> Glare <input type="checkbox"/> Not Obstructed	<p><b>Road Conditions</b></p> <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Snow <input type="checkbox"/> Ice <input type="checkbox"/> Slush <input type="checkbox"/> Mud <p><b>Light Conditions</b></p> <input type="checkbox"/> Daylight <input type="checkbox"/> Dark w/Street Light On <input type="checkbox"/> Dark w/Street Lights Off <input type="checkbox"/> Dark No Street Lights
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<b>ACCIDENT DIAGRAM</b>	<p><b>Vehicle #1 (YOU) Going</b></p> <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West	<p><b>Vehicle #2 Going</b></p> <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West
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Indicate North



**DESCRIBE THE ACCIDENT IN DETAIL (if additional space is needed, attach separate page)**

Report Made by:	Reviewed By/DSN:
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