



CITIZEN CRASH REPORT

Completed reports maybe submitted in person, mailed, or emailed to:
 Springfield Police Department - Attention: Central Records
 321 E. Chestnut Expressway, Springfield MO 65802
 Email: CentralRecords@springfieldmo.gov
 Call 417-864-1810 for additional information.

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

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

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		
Year:	Make:	Model:	Circle All Areas Of Damage			<input type="checkbox"/> Same as Driver #1 Information		
Color:	License Plate #:	State:	Front	VEH	Rear	Vehicle Owner's Name:		Phone #:
Insurance Company:						Vehicle Owner's Street Address:		
						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		
Year:	Make:	Model:	Circle All Areas Of Damage			<input type="checkbox"/> Same as Driver #2 Information		
Color:	License Plate #:	State:	Front	VEH	Rear	Vehicle Owner's Name:		Phone #:
Insurance Company:						Vehicle Owner's Street Address:		
						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							

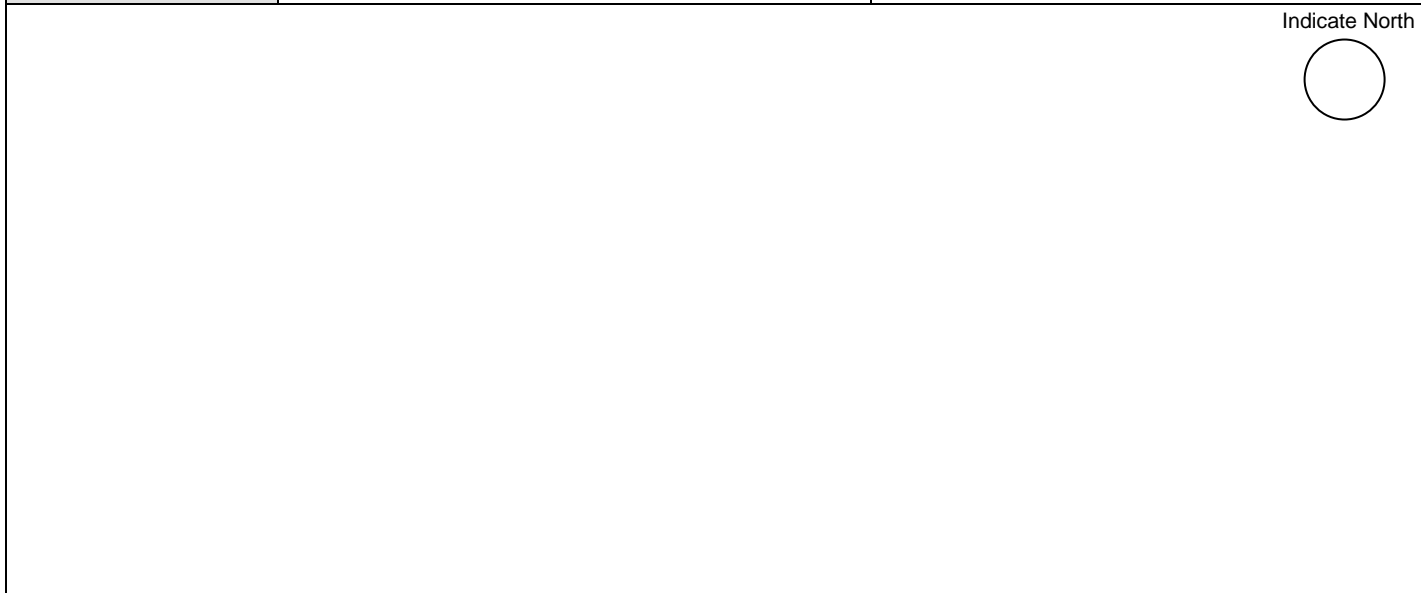
DAMAGE TO PROPERTY OTHER THAN VEHICLES

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

CRASH INFORMATION

<p>Collision Involving</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>Your Vehicle's Actions</p> <p>Please enter your vehicle's action(s) from the first event to its final rest in the space provided:</p> <p style="text-align: center;">/ /</p> <ol style="list-style-type: none"> 1. Going Straight 2. Overtaking 3. Making Right Turn 4. Right Turn on Red 5. Making Left Turn 6. Making U Turn 7. Skidding/Sliding 8. Slowing/Stopping 9. Start in Traffic 10. Start From Parked 11. Backing 12. Stopped in Traffic 13. Parked 	<p>Traffic Control</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>Vision Obstructed</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>Road Conditions</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>Light Conditions</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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CRASH DIAGRAM	Vehicle #1 (YOU) Going <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West	Vehicle #2 Going <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> East <input type="checkbox"/> West
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DESCRIBE THE CRASH IN DETAIL (if additional space is needed, attach separate page)

Signature of Reporting Party:	Date Signed:
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