A Public Service Agency

REPORT OF TRAFFIC ACCIDENT OCCURRING IN CALIFORNIA

READ IMPORTANT INFORMATION ON BACK

DMV USE ONLY

AS APPROPRIATE, PLEASE TYPE OR PRINT IN BOXES

# OF VEHICLES	DATE OF ACCIDENT	ACCIDENT LOCATION - CITY/COUNTY (**CALIFORNIA ONLY**)	ON PRIVATE PROPERTY ☐ Yes ☐ No

REPORTING PARTY'S INFORMATION

TIME OF ACCIDENT Hour ________ ☐ AM ☐ PM | ☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other *(E.G., ROLLAWAY)* | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (FIRST, MIDDLE, LAST)	DRIVER LICENSE NUMBER	STATE

DRIVER'S STREET ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )

VEHICLE (YEAR AND MAKE)	VEHICLE LICENSE PLATE **OR** VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $750 ☐ Yes ☐ No

VEHICLE OWNER—PERSON OR COMPANY	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER

COMPANY NAIC NUMBER	POLICY PERIOD From:____________ To:____________	POLICY HOLDER NAME

OTHER PARTY'S INFORMATION

☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other *(E.G., ROLLAWAY)* | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (FIRST, MIDDLE, LAST)	DRIVER LICENSE NUMBER	STATE

DRIVER'S STREET ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )

VEHICLE (YEAR AND MAKE)	VEHICLE LICENSE PLATE **OR** VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $750 ☐ Yes ☐ No

VEHICLE OWNER—PERSON OR COMPANY	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER

COMPANY NAIC NUMBER	POLICY PERIOD From:____________ To:____________	POLICY HOLDER NAME

INJURY/DEATH PROPERTY DAMAGE

NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Bicyclist	☐ Passenger ☐ Pedestrian
NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Bicyclist	☐ Passenger ☐ Pedestrian

OTHER PROPERTY DAMAGED *(TELEPHONE POLES, FENCE, LIVESTOCK, ETC.)*	DAMAGES OVER $750 ☐ Yes ☐ No

PROPERTY OWNER'S NAME AND ADDRESS

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE	PRINTED NAME	SIGNATURE X

☐ ADDITIONAL INFORMATION ATTACHED

A YOUR VEHICLE

CALIFORNIA INSURANCE INFORMATION — **DO NOT DETACH**

The Department may send this part to the **insurance company** indicated. If not **fully completed**, it will be assumed you were **not** insured for the accident and **your license will be suspended.**

DMV FILE NUMBER

INSURANCE

NAME OF INSURANCE COMPANY (NOT AGENCY OR BROKERAGE) THAT ISSUED THE LIABILITY POLICY COVERING THE OPERATION OF YOUR VEHICLE			
POLICY NUMBER	POLICY PERIOD From: To:		
DATE OF ACCIDENT	IN OR NEAR (CITY OR TOWN) **(CALIFORNIA ONLY)**	DRIVER LICENSE NUMBER (DRIVER OF YOUR VEHICLE)	
VEHICLE (YEAR AND MAKE)	VEHICLE IDENTIFICATION NUMBER	VEHICLE LICENSE PLATE NUMBER	STATE
DRIVER	ADDRESS		
OWNER	ADDRESS		
FULL NAME OF POLICY HOLDER	ADDRESS		

SR 1A (REV. 9/2008) **WWW**

If the policy was not in effect, this form must be completed and returned to the Department within 20 days.

The undersigned company advises that with respect to the reported accident, the policy reported on the reverse side:

☐ **WAS NOT** IN EFFECT

☐ Was not a liability policy ☐ Did not cover the vehicle/driver ☐ Number is not a company policy number

Policy Number ______________________ Policy Period from __________ to __________

Signature ______________________

Title ______________________

Date ______________________

MAIL TO:
Department of Motor Vehicles
Financial Responsibility
P. O. Box 942884
Sacramento, CA 94284-0884

INJURIES / LESIONES

Describe nature of any apparent injuries.
Describa la naturaleza de cualquier lesión aparente.

Driver / Conductor

Injury / Lesión

Passenger / Pasajero

Name / Nombre

Address / Dirección

Injury / Lesión

Other Driver / Otro conductor

Name / Nombre

Address / Dirección

Injury / Lesión

Other Passenger, Pedestrian / Otro pasajero, peatón

Name / Nombre

Address / Dirección

Injury / Lesión

Name / Nombre

Address / Dirección

Injury / Lesión

Where taken after accident / A dónde fueron llevados después del accidente

POLICE OFFICER ASSISTING / OFICIAL DE POLICÍA QUE AYUDÓ

Name / Nombre

Headquarters / Oficinas centrales

Police report made? / ¿Se hizo el reporte policial? ☐ Yes / Sí ☐ No / No

Badge No. / Núm. de identificación de la policía

Citations issued / Citatorios emitidos

PROPERTY DAMAGE / DAÑO A LA PROPIEDAD

Describe nature of damage.
Describa la naturaleza del daño.

Your Vehicle / Su vehículo

Other Vehicle / Otro vehículo

Owner / Propietario — Phone / Teléfono

Driver / Conductor — Phone / Teléfono

Vehicle Make / Marca de vehículo — License No. / Núm. de licencia

Insurance Company / Compañía de seguros

Property other than vehicles / Otras propiedades distintas a los vehículos

Owner / Propietario — Phone / Teléfono

WITNESSES / TESTIGOS

Name / Nombre — Phone / Teléfono

Address / Dirección

Name / Nombre — Phone / Teléfono

Address / Dirección

Name / Nombre — Phone / Teléfono

Address / Dirección

travelers.com

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CP-9000-Form Rev. 10-10

Oil & Gas
INDUSTRY *Edge*®

"On The Spot" Accident Report Form

My Name / Mi nombre — Age / Edad

Driver's License / Licencia del conductor — State / Estado

Employee No. / Núm. de empleado

My Vehicle / Mi vehículo

Year / Año — Make / Marca — Unit No. / Núm. de unidad

License No. / Núm. de licencia — State / Estado

Trailer Unit No. / Núm. de unidad del remolque

License No. / Núm. de licencia — State / Estado

☐ Company Owned / Compañía propietaria

☐ Owner Operator / Operador del propietario

Home Base / Casa

Job Title / Puesto de trabajo

☐ Business Use / Uso para trabajo

☐ Personal Use / Uso personal

Insurance Identification / Identificación Del Seguro

Policy Number / Número de la póliza

Insured's Name / Nombre del asegurado

Emergency Phone No. / Núm. telefónico de emergencia

Your Agent / Su agente

ACCIDENT INFORMATION / INFORMACIÓN DEL ACCIDENTE

Date / Fecha ________/________/________

Time / Hora ____________ ☐ AM ☐ PM

☐ Daylight / Luz de día ☐ Dark / Obscuro

Location / Ubicación

Name of Street or Highway Number / Nombre de la calle o número de autopista

Closest Intersection or Landmark / La intersección más cercana o punto de referencia

City, Town, County / Ciudad, pueblo, condado State / Estado

Weather / Clima

☐ Clear / Claro ☐ Raining / Lluvioso ☐ Snowing / Nevado
☐ Fog / Con neblina ☐ Sleeting / Aguanieve
☐ Dust/Smoke/Fog / Polvo/humo/neblina ☐ High Wind / Viento fuerte
☐ Other / Otro

Area / Área

☐ Residential / Residencial ☐ Commercial / Comercial
☐ Rural / Zona rural ☐ Other / Otro

Pavement / Pavimento

☐ Asphalt / Asfalto ☐ Concrete / Concreto
☐ Gravel/Dirt / Grava/tierra ☐ Brick/Stone / Ladrillo/piedra
☐ Steel / Acero ☐ Wood / Leñoso
☐ Other / Otro

Condition / Condición

☐ Dry / Seco ☐ Wet / Húmedo
☐ Slippery / Resbaloso ☐ Pot Holes / Baches
☐ Other / Otro

Direction / Dirección

Yours / Su dirección ☐ N ☐ E ☐ S ☐ W
☐ Other / Otro

Other / Otra ☐ N ☐ E ☐ S ☐ W
☐ Other / Otro

Speed / Velocidad

Yours / Su velocidad Posted / Publicado

Actual when danger noticed / Real cuando se observó el peligro

Other / Otra Posted / Publicado

Actual when danger noticed / Real cuando se observó el peligro

Traffic Control / Control De Tráfico

Stop sign / Señal de alto

☐ 1 Way / 1 carril ☐ 2 Way / 2 carriles ☐ 3 Way / 3 carriles
☐ Other / Otro
☐ Yield / Ceda el paso ☐ Semaphore / Semáforo
☐ Police/Flag Person / Policía/persona con banderola
☐ Railroad / Carretera
☐ Uncontrolled intersection / No controlada intersección
☐ Not an intersection / No es una intersección

Seat Belt / Asiento ☐ Used / Usado ☐ Not Used / Sin usar

Air Bag Inflated / Bolsa De Aire Inflada

☐ Yes / Sí ☐ No / No

Accident Description / Descripción Del Accidente

Briefly tell how the accident happened. Indicate movement of involved vehicles when hazard was first noticed, warning or evasive action taken and length and position of any skid marks.

Describa brevemente cómo sucedió el accidente. Indique el movimiento de los vehículos involucrados en el accidente cuando se dio cuenta por primera vez del riesgo, advertencia o acción evasiva tomada y la longitud y posición de cualquier marca del derrape.

Accident Sketch / Esquema Del Accidente

Draw an accident sketch. Show and label roadway, indicate number of lanes, direction of travel and signs. Number each vehicle and show direction of travel from point hazard was noticed to point of impact by a solid line and any travel after impact by a dotted line.

Dibuje un esquema del accidente. Muestre y etiquete la carretera, indique el número de carriles, la dirección de viaje y las señales. Enumere cada vehículo y muestre la dirección del viaje desde el punto en el que se dio cuenta del riesgo hasta el punto de impacto mediante una línea sólida así como cualquier viaje después del impacto mediante una línea pintada.

Symbols / Símbolos

1 Your vehicle / Su vehículo

2 Other vehicles / Otro vehículo

3

Pedestrian / Peatón

Stop sign / Alto

Semaphore / Semáforo

Yield / Con la señal ceda el paso

Railroad / Carretera

Point of impact / Punto de impacto

2

1

Indicate direction
Indique la dirección

At what distance did you notice danger?
¿A qué distancia observó el peligro?

__________ feet / pies

INCIDENT REPORT

TYPE OF INCIDENT: AUTO__________________ PROPERTY______________________________

DID YOU TAKE PICTURES OF BOTH VEHICLES (Regardless of amount of damage) ______________

DATE OF INCIDENT______________________ TIME OF INCIDENT_____________________________

INCIDENT OCCURRED AT:____
STREET ADDRESS OR INTERSECTIONS AND CITY

NAME OF PERSON(S) INVOLVED (Both parties)

____

____

ADDRESS OF PERSON(S) INVOLVED (Both parties)

____

____

INSURANCE COMPANY NAME (Other party)

____

INSURANCE CARD # OR POLICY # (Other party)

____

____

____

WERE THE POLICE CALLED: YES _________ NO_________

OFFICERS NAME____

BADGE NUMBER______________________________REPORT NUMBER__________________________

ANY VISUAL INJURIES OR COMPLAINTS OF INJURY (Both parties) : YES_________ NO__________

PLEASE SPECIFY:____

____

Additional Info

____

Fence Factory Injured Employee's Statement

To be completed by injured employee

I, ______________________ make the following report regarding my injury occurring at ______________ ______________________________

(location) ______________________________

on (date of injury) ______________________________

What were you doing at the time of injury/accident? ______________________________

____

____

How did the accident occur? ______________________________

____

____

Describe the injury (be specific, part of body, etc.) ______________________________

____

____

Have you ever had an injury to this part of the body before? ☐ Yes ☐ No

Do you feel this accident aggravated a previous condition? ☐ Yes ☐ No

(If yes, explain) ______________________________

____

____

Were you instructed to do the specific task you were doing when the accident occurred?

☐ Yes ☐ No

If yes, by whom? ______________________________

What could have been done to prevent this accident/injury? ______________________________

____

____

Please describe any safety hazards you observed. ______________________________

____

____

Employer's Signature ______________________________ Date ______________

Supervisor's Signature ______________________________ Date ______________

- ✓ Copy to Safety Officer immediately
- ✓ Copy for Employee's Accident File and Safety Office

Fence Factory
Supervisor's Accident Investigation Report
(To be completed as soon as possible)

Supervisor Completing Form: ______________________________

1. Date and time of injury/accident/illness: ______________________________

____

2. Name(s) of employee(s) (accident/injury): ______________________________

3. Was this a First Aid only? If so describe treatment: ______________________________

____

4. Work area/job of employee(s)involved: ______________________________

____

5. Nature of accident/injury or illness: ______________________________

____

____

6. Part(s) of body affected: ______________________________

____

____

7. Was employee performing normal occupation/job at time of accident/injury?

❑ Yes ❑ No

8. Did employee leave work? Date: ____________ Time: ____________

❑ Yes ❑ No

9. Did employee return to work? Date: ____________ Time: ____________

❑ Yes ❑ No

10. Name of witness(s) ______________________________

____

11. Where and by whom was injured worker treated? ______________________________

____

12. What was the accident/injured worker doing? ______________________________

____

13. What workplace condition, work practice or protective equipment contributed to the accident/injury? ______

14. Was a safety rule violated? ❑ Yes ❑ No

If Yes, which one? ______

15. What corrective actions will prevent recurrence? ______

______

______

16. Was the unsafe condition, practice or protective equipment problem corrected immediately?

If Yes, how? ______

If No, what has been done? ______

17. Until corrected, what actions have been taken to prevent recurrence in the interim?

______

______

Note: The results of the investigation should be communicated to affected employees, the Safety Officer, management and others responsible for follow-up actions.

Safety Officer to complete section below

Date and Time of Investigation: ______

Were all-correct accident reporting procedures followed? ❑ Yes ❑ No

If no indicate errors/problems: ______

What actions in your opinion need to take place to correct hazard/accident in the future? ______

______

Have the correct actions to prevent recurrence been taken? ❑ Yes ❑ No

If not what still needs done? ______

Was training conducted? ❑ Yes ❑ No

When? ______ Subject ______

If No Date/Time to be completed. ______

Any required further investigation? ______

Any discipline necessary? ❑ Yes ❑ No

If yes comment ______

- ✓ Copy for Safety Officer
- ✓ Copy for Employee Accident File

Witness card

Did you see the accident? []Yes []No

Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

Did you see the accident? []Yes []No

Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

Did you see the accident? []Yes []No

Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

Did you see the accident? []Yes []No

Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

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If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

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If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

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Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.

Witness card

Did you see the accident? []Yes []No

Did anyone appear injured? []Yes []No

Were you riding in a vehicle involved? []Yes []No

If yes, which one? ______________________________________

Your Name: ____

Phone Number:(_______)__________-___________________

Please return this card. Thank you for your help.