

# VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)			DATE OF ACCIDENT(mm/dd/yyyy)			TIME				
							AM <input type="checkbox"/> PM <input type="checkbox"/>				
	CURRENT STREET (RESIDENCE) ADDRESS			CITY			STATE				
							ZIP				
(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT			CITY			STATE					
						ZIP					
						EMAIL					
State/County/City (if applicable) where occurred			STREET OR HWY			MILEPOST NO.					
						INTERSECTION OR NEAREST STREET/ROAD					
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?			WHEN?			
	NAME OF VEHICLE OWNER			ADDRESS			CITY				
							HOME AND WORK PHONE				
	NAME OF DRIVER			ADDRESS			CITY				
							HOME AND WORK PHONE				
	DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE			DATE OF EXPIRATION				
DESCRIBE DAMAGE				ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.						
OTHER VEHICLE INFORMATION (VEHICLE #2)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN						
	NAME OF OWNER			ADDRESS			CITY				
							PHONE				
	NAME OF DRIVER			ADDRESS			CITY				
							PHONE				
	DESCRIBE DAMAGE				ESTIMATE \$						
WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.											
OTHER NON-VEHICLE DAMAGE	NAME OF OWNER			ADDRESS			CITY				
							PHONE				
	DESCRIBE DAMAGE				ESTIMATE \$						
INJURED PARTIES	NAME	ADDRESS		PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)			ADDRESS			CITY				
							PHONE				
							HOME WORK				
							HOME WORK				

**COMPLETE ALL DETAILS**

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

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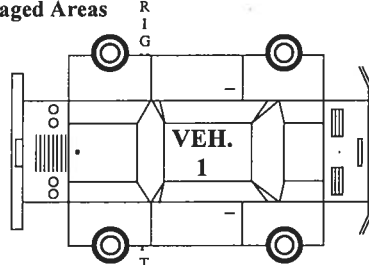
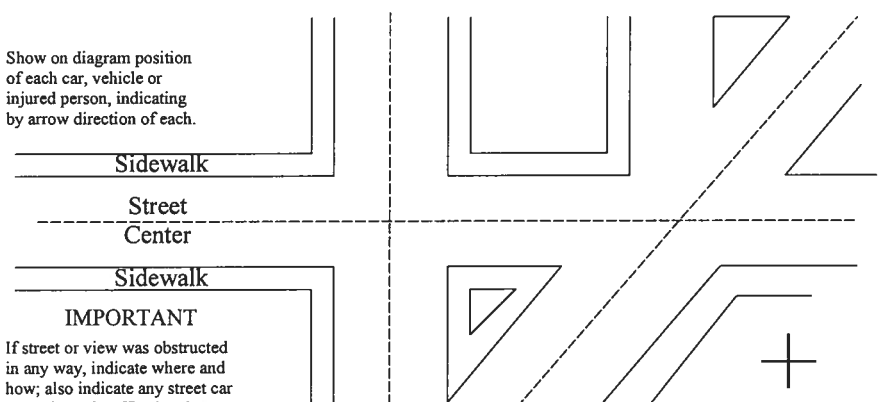
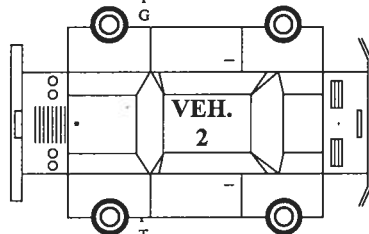

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<input type="checkbox"/> Straight Road <input type="checkbox"/> Curve - R or L <input type="checkbox"/> Level	<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill	<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane	<b>Mark Damaged Areas</b> 
<p>Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.</p> 			
<p><b>IMPORTANT</b> If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.</p>			<p>Indicate points of compass N. E. S. W.</p> 

LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 <input type="checkbox"/> DAYLIGHT	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 2 <input type="checkbox"/> STOP SIGN	<input type="checkbox"/> 2 <input type="checkbox"/> TWO WAY	<input type="checkbox"/> 2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	<input type="checkbox"/> 2 <input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<input type="checkbox"/> 3 <input type="checkbox"/> FLASHING RED	<input type="checkbox"/> 3 <input type="checkbox"/> REVERSIBLE ROAD	<input type="checkbox"/> 3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	<input type="checkbox"/> 3 <input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<input type="checkbox"/> 4 <input type="checkbox"/> FLASHING AMBER	<input type="checkbox"/> 4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	<input type="checkbox"/> 4 <input type="checkbox"/> TIRES WORN	<input type="checkbox"/> 4 <input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<input type="checkbox"/> 5 <input type="checkbox"/> RR SIGNAL	<input type="checkbox"/> 5 <input type="checkbox"/> ALLEY	<input type="checkbox"/> 5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<input type="checkbox"/> 6 <input type="checkbox"/> OFFICER/FLAGMAN	<input type="checkbox"/> 6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	<input type="checkbox"/> 6 <input type="checkbox"/> OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: _____  INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED			
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			

**A separate claim form should be submitted for each claimant.**

This information is being provided to aid in resolving the claim.

***I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.***

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date and Place (residential address, city and county)