

This report must be filed regardless of amount of damages

Driver's License #
Traveler's Insurance Claim #

I. DRIVER & STATE OWNED VEHICLE

Name:		Department:		Office Phone:
Home Address:				Vehicle Color:
Vehicle No:	Year:	Make:	Serial No:	License Plate No:
Describe damage to state owned vehicle:				

II. SECOND PARTY & NON-STATE VEHICLE

Owner:			Driver (if not owner):		
Address:			Address:		
Driver License No:	Home Phone:		Vehicle Color:	Home Phone:	
Type Vehicle:	Year:	Make:	License No:	Insurance Co:	Policy No:
Describe damage to non-state vehicle:					

III. INJURED:

Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Describe Injuries:	Describe Injuries:

IV. ACCIDENT

Location: (Street(s), City)			County:
Date:	Time:	Investigating Officer:	
Describe accident in detail (use back of form to continue/diagram accident):			

V. WITNESSES

Name:	Name:
Address:	Address:
Return to: MOTOR FLEET MANAGEMENT DIVISION 1308 MAIL SERVICE CTR. RALEIGH, NORTH CAROLINA 27699-1308 FAX # 919-733-4074	Signature, state owned vehicle driver:
	Date: