FM-16
(REV 4-03)

N.C Department of Administration
Motor Fleet Management Division
VEHICLE ACCIDENT REPORT

This report must be filed regardless of amount of damages

Driver's License #

Traveler's Insurance Claim #

1. 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: