

RM-1A supersedes RM1.2				State of New Jersey Vehicle Accident Report			Print or Type Only		Agency Use only - Loc #	
Accident Date	Day of Week	Time	AM PM	# of Vehicles	# Killed	# Injured	Name of Police Dept or Investigating Agency			
Location of Accident (Municipality)			Route # or Name of Street			If not an intersection, Collision was Between:				
County			Intersecting Street, Road, or Railroad			ROAD 1 _____ ROAD 2 _____ Distance from Road _____				
STATE VEHICLE 1		Was Citation Issued? YES <input type="checkbox"/> NO <input type="checkbox"/>		Citation to Whom?		State Driver		Other Driver Vehicle # -		
State Driver (Last Name)		State Driver (First Name)		State Driver (Middle Initial)		State Driver Phone Number ()				
Home Address (Number)		Home Address (Street)		Home Address (City)		Home Address (State)		Home Address (Zip)		
Social Security Number		Age	Sex	Driver's License Number		State	Dept. / Div.			
Make of vehicle		Year of vehicle	License Plate Number / St. #		Vehicle Owner / Lessor					
Employer's Workstation Address (Number)		Employer's Workstation Address (Street)		Employer's Workstation Address (City)		Employer's Workstation Address (State)		Employer's Workstation Address (Zip)		
OTHER VEHICLE 2		Insurance Company			Policy Number					
Other Driver (Last Name)		Other Driver (First Name)		Other Driver (Middle Initial)		Other Driver Phone Number ()				
Driver's Address (Number)		Driver's Address (Street)		Driver's Address (City)		Driver's Address (State)		Driver's Address (Zip)		
Birth date	Eye Color	Sex	Driver's License Number		State	Make of Vehicle	Year	License Plate #	State	
Vehicle Owner (Last Name/Company)		Vehicle Owner (First Name)		Vehicle Owner (Middle Initial)		Vehicle Owner Phone Number ()				
Owner's Address (Number)		Owner's Address (Street)		Owner's Address (City)		Owner's Address (State)		Owner's Address (Zip)		
Persons Injured (Other Than State Driver)	1	Name & Address		Tel. NO. ()		Passenger in:		Extent of Injury:		
						State Car <input type="checkbox"/>	Other Car <input type="checkbox"/>	Ped <input type="checkbox"/>	Severe <input type="checkbox"/> Slight <input type="checkbox"/>	
	2	Name & Address		Tel. NO. ()		Passenger in:		Extent of Injury:		
					State Car <input type="checkbox"/>	Other Car <input type="checkbox"/>	Ped <input type="checkbox"/>	Severe <input type="checkbox"/> Slight <input type="checkbox"/>		
	3	Name & Address		Tel. NO. ()		Passenger in:		Extent of Injury:		
						State Car <input type="checkbox"/>	Other Car <input type="checkbox"/>	Ped <input type="checkbox"/>	Severe <input type="checkbox"/> Slight <input type="checkbox"/>	

TYPE OF STATE VEHICLE Specialized equipment such as bulldozers, graders, street sweepers, backhoes, forklifts, lawnmowers & other similar equipment.

Fire engines, ambulances, Etc.

- Subcompact
- Compact
- Passenger car/truck
- Vans used for transporting people
- All other vans
- Utility Vehicles & Pick up trucks
- Light Truck - Wt. 5,000 - 10,000 lbs.
- Medium Truck - Wt. 10,001 - 20,000 lbs.
- Heavy Trucks - Wt. 20,001 - 45,000 lbs.
- Data Heavy Trucks - Wt. over 45,000 lbs.
- Misc Equipment
- Buses

ENVIRONMENTAL CONDITIONS

Weather 1. Clear 2. Rain 3. Snow 4. Fog 5. Other

Surface Condition 1. Dry 2. Wet 3. Snow 4. Ice 5. Other

Light Condition 1. Daylight 2. Dawn or Dusk 3. Dark (Street lights on) 4. Dark (Street lights off) 5. Dark (No Lights)

Collision Involved With 1. Pedestrian 2. Other motor Veh. 3. Overturned 4. Peda'l cycle 5. Moped or Motorcycle 6. Animal 7. Fixed Object 8. Other object

Delinquent Driving within the last 36 months?
1 - Yes Date ____/____/____**
2 - No ** IF "YES" Date must be indicated

Information in this area to be Provided by Employee's Supervisor.

STATE DRIVER INJURIES

- First aid or other non recordable incident
- Medical Treatment
- Medical Treatment - Employee transferred
- Medical Treatment - Employee terminated
- Loss of consciousness - no medical treatment
- Lost work day case
- Lost work day case - Employee transferred
- Lost work day case - Employee terminated
- Fatality Fatality Date ____/____/____

Vehicle Use 1. Normal job related operations 2. Commuting to or from home and place of work (temp or permanent)
3. Commuting to or from breakfast, lunch or dinner and place of work.
 4. Other (define) _____
DOT use only - 5. Striping 6. Sanding 7. Snow Plowing 8. Road or Bridge Maint.
NJSP use only - 9. Pursuit 10. Response 11. Surveillance

Loss of workdays off job
Estimated _____ Actual _____
Count work days (consecutive or not). Employee would have worked, but could not because of occupational injury or illness. Don't count day of injury, holidays or normal days off.

Workdays on Modified Job
Estimated _____ Actual _____
Enter total of 1. Days assigned to temporary job 2. Part time days on regular job. 3. Days on regular job but unable to perform at normally connected rates.

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