

RM-1A supersedes RM1.2				State of New Jersey Vehicle Accident Report			Print or Type Only		Agency/Use only - Loc 8.		
Accident Date		Day of Week		Time <input type="checkbox"/> AM <input type="checkbox"/> 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: ROAD 1 _____ ROAD 2 _____ Distance from Road _____			
County				Intersecting Street, Road, or Railroad							
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)		(First Name)		(Middle Initial)		Phone Number ()					
Home Address (Number)		(Street)		(City)		(State)		(Zip)			
Social Security Number		Age		Sex		Driver's License Number		State		Dept / Div.	
Make of Vehicle		Year of Vehicle		License Plate Number / S.C.#		Vehicle Owner / Lessor					
Employee's Workstation Address (Number)		(Street)		(City)		(State)		(Zip)			
OTHER VEHICLE 2		Insurance Company				Policy Number					
Other Driver (Last Name)		(First Name)		(Middle Initial)		Phone Number ()					
Driver's Address (Number)		(Street)		(City)		(State)		(Zip)			
Birth date		Eye Color		Sex		Driver's License Number		State		Make of Vehicle	
Year		License Plate #		State							
Vehicle Owner (Last Name/Company)		(First Name)		(Middle Initial)		Phone Number ()					
Owner's Address (Number)		(Street)		(City)		(State)		(Zip)			
Persons Injured (Other Than State Driver)		1 Name & Address		Tel. NO. ()		Passenger in: State Car <input type="checkbox"/> Other Car <input type="checkbox"/> Ped <input type="checkbox"/>		Extent of Injury: Severe <input type="checkbox"/> Slight <input type="checkbox"/>			
2		Name & Address		Tel. NO. ()		Passenger in: State Car <input type="checkbox"/> Other Car <input type="checkbox"/> Ped <input type="checkbox"/>		Extent of Injury: Severe <input type="checkbox"/> Slight <input type="checkbox"/>			
3		Name & Address		Tel. NO. ()		Passenger in: State Car <input type="checkbox"/> Other Car <input type="checkbox"/> Ped <input type="checkbox"/>		Extent of Injury: Severe <input type="checkbox"/> Slight <input type="checkbox"/>			

TYPE OF STATE VEHICLE		<input type="checkbox"/> *Specialized equipment such as bulldozers, graders, street sweepers, backhoes, forklifts, lawnmowers & other similar equipment. Fire engines, ambulances, Etc.
1. Subcompact		
2. Compact		
3. Passenger car/cabriolet wagons		
4. Vans used for transporting people		
5. All other Vans		
6. Utility Vehicles & Pick up trucks		
7. Light Truck - WT. 5,000 - 10,000 Lbs.		
8. Medium Truck - WT. 10,001 - 20,000 Lbs.		
9. Heavy Trucks - WT. 20,001 - 45,000 Lbs.		
10. Extra Heavy Trucks - WT. over 45,000 Lbs.		
11. Misc Equipment**		
12. Buses		
ENVIRONMENTAL CONDITIONS		
Weather		1. Clear 2. Rain 3. Snow 4. Fog 5. Other <input type="checkbox"/>
Surface Condition		1. Dry 2. Wet 3. Snow 4. Ice 5. Other <input type="checkbox"/>
Light Condition		1. Daylight 2. Dawn or Dusk 3. Dark (Street lights on) 4. Dark (Street lights off) 5. Dark (No Lights) <input type="checkbox"/>
Collision Involved With		1. Pedestrian 2. Other motor Veh. 3. Overturned 4. Pedal cycle 5. Moped or Motorcycle 6. Animal 7. Fixed Object 8. Other object <input type="checkbox"/>
Defensive Driving within the last 36 months? 1 - Yes <input type="checkbox"/> Date ____/____/____** 2 - No ** IF "YES" Date must be indicated		
Information in this area to be Provided by Employee's Supervisor. <input type="checkbox"/>		
STATE DRIVER INJURIES		
1. First aid or other non recordable incident		
2. Medical Treatment		
3. Medical Treatment - Employee transferred		
4. Medical Treatment - Employee terminated		
5. Loss of consciousness - no medical treatment		
6. Lost work day case		
7. Lost work day case - Employee transferred		
8. Lost work day case - Employee terminated		
9. Fatality Fatality Date ____/____/____		
Vehicle 1. Normal job related operations 2. Commuting to or from home and place of work (temp or permanent) Use 3. Commuting to or from breakfast, lunch or dinner and place of work. <input type="checkbox"/> 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 all normally connected duties.		

Nj Accident Report Form

A Gutmann

A red circular graphic with a gradient, appearing as a stylized arrow or a partial circle, located to the right of the author's name.

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