

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 / Sq. Ft.		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	
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:		Extent of Injury:	
	2	Name & Address				Tel. NO. ()		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. ()		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		<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.

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.

☐ 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

K Morrison

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

Nj Accident Report Form:

Decoding **Nj Accident Report Form**: Revealing the Captivating Potential of Verbal Expression

In an era characterized by interconnectedness and an insatiable thirst for knowledge, the captivating potential of verbal expression has emerged as a formidable force. Its ability to evoke sentiments, stimulate introspection, and incite profound transformations is genuinely awe-inspiring. Within the pages of "**Nj Accident Report Form**," a mesmerizing literary creation penned with a celebrated wordsmith, readers set about an enlightening odyssey, unraveling the intricate significance of language and its enduring effect on our lives. In this appraisal, we shall explore the book's central themes, evaluate its distinctive writing style, and gauge its pervasive influence on the hearts and minds of its readership.

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Table of Contents Nj Accident Report Form

1. Understanding the eBook Nj Accident Report Form
 - The Rise of Digital Reading Nj Accident Report Form
 - Advantages of eBooks Over Traditional Books
2. Identifying Nj Accident Report Form
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Nj Accident Report Form
 - User-Friendly Interface
4. Exploring eBook Recommendations from Nj Accident Report Form
 - Personalized Recommendations
 - Nj Accident Report Form User Reviews and Ratings

- Nj Accident Report Form and Bestseller Lists
- 5. Accessing Nj Accident Report Form Free and Paid eBooks
 - Nj Accident Report Form Public Domain eBooks
 - Nj Accident Report Form eBook Subscription Services
 - Nj Accident Report Form Budget-Friendly Options
- 6. Navigating Nj Accident Report Form eBook Formats
 - ePub, PDF, MOBI, and More
 - Nj Accident Report Form Compatibility with Devices
 - Nj Accident Report Form Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Nj Accident Report Form
 - Highlighting and Note-Taking Nj Accident Report Form
 - Interactive Elements Nj Accident Report Form
- 8. Staying Engaged with Nj Accident Report Form
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Nj Accident Report Form
- 9. Balancing eBooks and Physical Books Nj Accident Report Form
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Nj Accident Report Form
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Nj Accident Report Form
 - Setting Reading Goals Nj Accident Report Form
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Nj Accident Report Form
 - Fact-Checking eBook Content of Nj Accident Report Form
 - Distinguishing Credible Sources

13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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