

RM-1A supersedes RM1.2				<b>State of New Jersey Vehicle Accident Report</b>			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							
<b>STATE VEHICLE 1</b>		Was Citation Issued? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		Citation to Whom?		<b>State Driver</b>		<b>Other Driver Vehicle # -</b>			
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)			
<b>OTHER VEHICLE 2</b>		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)			
<b>Persons Injured (Other Than State Driver)</b>	<b>1</b>	Name & Address				Tel. NO. ( )		Passenger in:		Extent of Injury:	
	<b>2</b>	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"/>	
	<b>3</b>	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"/>	

<b>TYPE OF STATE VEHICLE</b>		<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		
<b>ENVIRONMENTAL CONDITIONS</b>		
<b>Weather</b>	1. Clear 2. Rain 3. Snow 4. Fog 5. Other <input type="checkbox"/>	
<b>Surface Condition</b>	1. Dry 2. Wet 3. Snow 4. Ice 5. Other <input type="checkbox"/>	
<b>Light Condition</b>	1. Daylight 2. Dawn or Dusk 3. Dark (Street lights on) 4. Dark (Street lights off) 5. Dark (No Lights) <input type="checkbox"/>	
<b>Collision Involved With</b>	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.

<b>STATE DRIVER INJURIES</b>		<input type="checkbox"/>
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

**Thomas Griffiths**

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:**

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