VEHICLE DAMAGE REPORT

CADETS ARTS & ENTERTAINMENT, INC.

This report must be completed by a supervisor or manager.

Company name: Today's Date:

DRIVER INFORMATION

Driver's name:

License number:

Date of birth:

Length of employment:

Address:

City: State: Zip: County:

Phone: Cell:

Job title:

Reason vehicle was used:

Used with permission from:

Vehicle 1 Information (Insured Driver)

VIN: Year: Make: Model:

Insurance company: Policy number:

Does the vehicle require towing? Yes ☐ No ☐

Description of damage:

Vehicle 2 Information

VIN: Year: Make: Model:

Insurance company: Policy number:

Does the vehicle require towing? Yes ☐ No ☐

Description of damage:

Vehicle 3 Information

VIN: Year: Make: Model:

Insurance company: Policy number:

Does the vehicle require towing? Yes ☐ No ☐

Description of damage:

Vehicle 4 Information

VIN: Year: Make: Model:

Insurance company: Policy number:

Does the vehicle require towing? Yes ☐ No ☐

Description of damage:

ACCIDENT INFORMATION

Accident Date (MM/DD/YY): Time of accident: AM ☐ PM ☐

Accident location: City: State: Zip: County:

Purpose of trip

Pick-up: ☐

Driving to job site: ☐

Returning from job site: ☐

Delivery: ☐

Personal Time: ☐

Other, please explain:

Weather

Clear: ☐

Cloudy: ☐

Rain: ☐

Snow: ☐

Fog: ☐

Sleet: ☐

Other:

Condition of road surface

Wet: ☐

Dry: ☐

Ice: ☐

Concrete: ☐

Asphalt: ☐

Gravel: ☐

Uneven: ☐

Other:

Lanes divided? Yes: ☐ No: ☐

Traffic control device? Yes: ☐ No: ☐

Number of hours on duty at time of accident:

Number of driving hours:

Describe how the accident happened:

Use a separate page if you need to draw a diagram of accident.

Were there any injuries? Yes: ☐ No: ☐

1. Name of first injured party: Telephone Number:

Were injuries fatal? Yes: ☐ No: ☐

Do injuries require treatment away from accident scene? Yes: ☐ No: ☐

Injured party's address: City: State: Zip: County:

What vehicle was injured person in?

Vehicle 1: ☐

Vehicle 2: ☐

Vehicle 3: ☐

Vehicle 4: ☐

Other: : ☐

If other, please explain:

Was injured party taken to the hospital? Yes: ☐ No: ☐

Name of hospital:

Give brief description of injuries:

2. Name of second injured party: Telephone Number:

Were injuries fatal? Yes: ☐ No: ☐

Do injuries require treatment away from accident scene? Yes: ☐ No: ☐

Injured party's address: City: State: Zip: County:

What vehicle was injured person in?

Vehicle 1: ☐

Vehicle 2: ☐

Vehicle 3: ☐

Vehicle 4: ☐

Other: : ☐

If other, please explain:

Was injured party taken to the hospital? Yes: ☐ No: ☐

Name of hospital:

Give brief description of injuries:

3. Name of third injured party: Telephone Number:

Were injuries fatal? Yes: ☐ No: ☐

Do injuries require treatment away from accident scene? Yes: ☐ No: ☐

Injured party's address: City: State: Zip: County:

What vehicle was injured person in?

Vehicle 1: ☐

Vehicle 2: ☐

Vehicle 3: ☐

Vehicle 4: ☐

Other: : ☐

If other, please explain:

Was injured party taken to the hospital? Yes: ☐ No: ☐

Name of hospital:

Give brief description of injuries:

OTHER INFORMATION

Was there any property damage? Yes: ☐ No: ☐ If yes, give brief description:

Property damage address: City: State: Zip: County:

Were the police called? Yes: ☐ No: ☐ Did the police respond? Yes: ☐ No: ☐

Police report #: Officer:

Was a citation issued? Yes: ☐ No: ☐ If yes, to whom?

Citation Description:

Was drug testing administered? Yes: ☐ No: ☐ Was alcohol testing administered? Yes: ☐ No: ☐

Chain of Custody No.:

WITNESSES

1. First witness name:

Address: City: State: Zip: County:

Home Phone: Work Phone: Cell Phone:

2. Second witness name:

Address: City: State: Zip: County:

Home Phone: Work Phone: Cell Phone:

3. Third witness name:

Address: City: State: Zip: County:

Home Phone: Work Phone: Cell Phone:

PERSON COMPLETING FORM

Name:

Date: