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	# of Vehicles	# Killed	# Injured	Name of Police Dept or Investigating Agency
		☐ AM ☐ PM				

Location of Accident (Municipality) | Route # or Name of Street

County | Intersecting Street, Road, or Railroad

If not an Intersection, Collision was Between:
ROAD 1_____
ROAD 2_____
Distance from Road_____

STATE VEHICLE 1

Was Citation Issued ? YES ☐ NO ☐

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.

Made of Vehicle	Year of Vehicle	License Plate Number / SG #	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)

	Name & Address	Tel. NO.	Passenger in:	Extent of Injury:
1		( )	State Car ☐ Other Car ☐ Ped ☐	Severe ☐ Slight ☐
2		( )	State Car ☐ Other Car ☐ Ped ☐	Severe ☐ Slight ☐
3		( )	State Car ☐ Other Car ☐ Ped ☐	Severe ☐ Slight ☐

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

TYPE OF STATE VEHICLE ☐ ***Specialized equipment such as bulldozers, graders, street sweepers, back-hoes, forklifts, lawnmowers & other similar equipment.**

1. Subcompact
2. Compact
3. Passenger cars/station 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. Mics Equipment *
12. Buses

Fire engines, ambulances, Etc.

ENVIRONMENTAL CONDITIONS

Weather ☐ 1. Clear 2. Rain 3. Snowy 4. Fog 5. Other

Surface Condition ☐ 1. Dry 2. Wet 3. Snow 4. Icy 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. Pedal cycle 5. Moped or Motorcycle 6. Animal 7. Fixed Object 8. Other object

Defensive 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

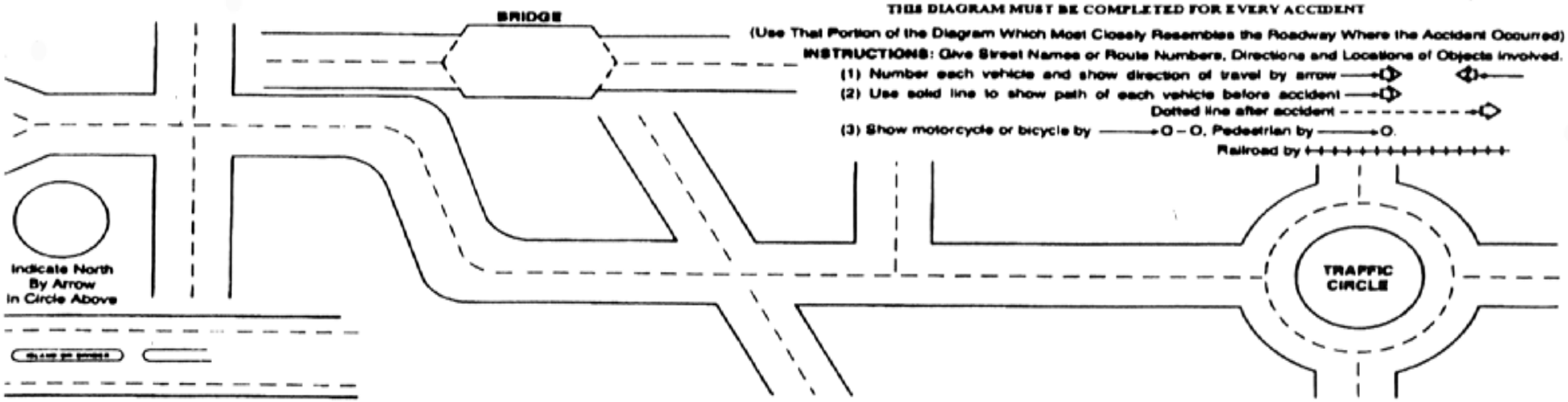
0. First aid or other non recordable Incident
1. Medical Treatment
2. Medical Treatment - Employee transferred
3. Medical Treatment - Employee terminated
4. Loss of consciousness - no medical treatment
5. Lost work day case
6. Lost work day case - Employee transferred
7. Lost work day case - Employee terminated
8. Fatality Fatality Date ____/___/_____

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**_____

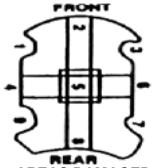
Enter total of 1. Days assigned to temporary job. 2. Part time days on regular job. 3. Days on regular job but unable to perform all normally connected duties.



DESCRIPTION OF ACCIDENT PRINT CLEARLY !	Refer to vehicles by number - Give direction and approximate speed of each vehicle. Include description of property damage other than vehicle damage.
	ADD SUPPLEMENTAL SHEETS AS NECESSARY

☐ V1 ☐ V2

INDICATE INITIAL IMPACT DAMAGE



Did Airbags deploy?

Yes ☐ No ☐

AREAS DAMAGED	V1	V2
10 Undercar Damage	☐	☐
11 Overturned	☐	☐
12 Totalled	☐	☐
13 None or Unknown	☐	☐
14 Other	☐	☐

WITNESS	NAME	ADDRESS	TELEPHONE NUMBER	APPROVAL	SIGNATURE OF STATE DRIVER COMPLETING THIS FORM	DATE	TITLE & ORGANIZATION	TELEPHONE NUMBER
			( )					( )
	NAME	ADDRESS	TELEPHONE NUMBER		SIGNATURE OF DRIVER'S SUPERVISOR	DATE	TITLE	TELEPHONE NUMBER
			( )					( )
	NAME	ADDRESS	TELEPHONE NUMBER		SIGNATURE OF FLEET LIASION OFFICER	DATE	TITLE	TELEPHONE NUMBER
			( )					( )

POLICE REPORT TO BE FORWARDED AS SOON AS POSSIBLE

PRINT ON BLUE PAPER, SIGN AND FORWARD TO FLEET LIAISON OFFICER