RM - 1B

Print or Type only	State of New Jersey Vehicle INCIDENT Form	

Incident Date	Day of Wk.	Time ☐ AM ☐ PM	Name of Police Dept. or Agency Investigating Incident

Location of Accident (Municipality)	Route # or Name of Street
County	Intersecting Street, Road or Railroad

State Vehicle	

State Driver (Last Name)	(First Name)	(Middle Initial)	Phone Number ( )

Home Address (Number)	(Street)	(City)	(State)	(Zip)

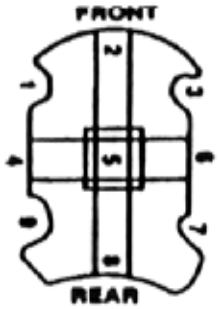
Social Security Number - -	Age	Sex	Driver's License Number	State	Agency

Made of Vehicle	Year of Vehicle	License Plate / SG #	Vehicle Owner / Lessor

Owner's Address (Number)	(Street)	(City)	(State)	(Zip)

VANDALISM: YES ☐ NO ☐ **STOLEN:** ☐ YES ☐ NO

Description of INCIDENT Refer to Vehicles by number - Give direction and approximate speed of each vehicle. Include description of property damaged other than vehicle damage



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

Add supplemental Sheets as necessary

WITNESS			APPROVAL			
Name	Address	Phone # ( )	Signature of Driver	Date	Title	Phone # ( )
Name	Address	Phone # ( )	Signature of Driver's Supervisor	Date	Title	Phone # ( )
Name	Address	Phone # ( )	Signature of Veh. Coordinator	Date	Title	Phone # ( )

PRINT ON GREEN PAPER, SIGN AND FORWARD TO FLEET VEHICLE COORDINATOR