



OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Instructions

Tear this sheet off your report, read and carefully follow the directions.

ONLY drivers involved in an accident resulting in any of the following MUST file an Accident Report:

- **Damage to any one person's property over \$1000;**
- **Injury (No matter how minor); or**
- **Death.**

Oregon law requires these reports be filed within 72 hours of the accident. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the accident to DMV, it may result in suspension of your driving privileges. If the police department files a police report, you are **still** required to file your own Accident Report with DMV. If you are an out-of-state resident, you are **still** required to file your own Accident Report with DMV. DMV does not determine fault in an accident, but does post the accident to the driving record of each driver involved, unless the vehicle is parked. If you have questions, please call the Accident Unit at (503) 945-5098.

PRINT OR TYPE ALL INFORMATION. (Use black or dark blue ink and press firmly.)

- Complete both sides of the form.
- If additional vehicles were involved in the accident, complete the *Supplemental Report* (Form 735-32B), or on a blank piece of paper, write all the information as requested in the "Other Driver" section.
- Mail the form to Accident Reporting Unit, DMV, 1905 Lana Ave NE, Salem OR 97314, or deliver it to any DMV office.
- DMV headquarters will verify the insurance information submitted. Complete the insurance section or a suspension of your driving privileges may occur.

DATE, LOCATION AND TIME — Clearly identify the date, location and time of the accident. The correct date, location and time is critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

YOUR VEHICLE (No. 1) — DMV will consider your accident uninsured if you do not complete **ALL** of this section. You must list the insurance company name that provided **liability coverage** for your operation of the vehicle you were driving at the time of the accident. Note the coverage is for **liability insurance**, not collision or comprehensive coverage. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

Answer all of the employment questions. DMV will use the information provided in these questions to code the accident. It is important for you to understand "principal purpose of driving" and "paid to drive." These include **ONLY** persons employed or being paid for the purpose of driving, **NOT** driving to reach a destination to perform a service.

NOTE TO COMMERCIAL MOTOR VEHICLE OPERATORS: In addition to this report, Oregon Law requires Form 735-9229, *Motor Carrier Accident Report*, **MUST** be filed within 30 days of a commercial motor vehicle accident when there is a **FATALITY**, **INJURY** (requiring treatment away from the scene), or when a vehicle is **TOWED** from the scene because of damage. For questions regarding the *Motor Carrier Accident Report*, call (503) 986-3507.

OTHER VEHICLE (No. 2) — Completion of this information will help DMV match all driver's accident reports more efficiently.

SIGNATURE — It is important for you to sign and date the form.

OTHER SIDE OF FORM — Complete the other side of the form. Information collected from both sides of this form is used by DMV and other officials in making valuable transportation decisions about the roadway systems and driver safety.

YOUR COPY — Under Oregon law 802.220 (5), DMV can not provide you a copy of your *Oregon Traffic Accident and Insurance Report*. If you wish to have a complete copy of your report (front and back), **you** will need to make a copy for **your** records.

RECEIPT — Attached is a PINK courtesy copy of your report. After you have completed both sides of the form, tear the PINK copy off for your records. If you want a receipt, bring the form, with the PINK copy, to a DMV office and have your copy validated. **Without a receipt, you will have no proof of submitting a report.**

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY CAN NOT REQUIRE REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

TOTALED VEHICLE NOTICE

DEFINITIONS AND INSTRUCTIONS FOR TOTALED VEHICLES

IF YOUR ACCIDENT HAS RESULTED IN A "TOTALED" VEHICLE, YOU ARE REQUIRED BY LAW TO FOLLOW APPROPRIATE INSTRUCTIONS IN THIS NOTICE.

DEFINITION OF "TOTALED" VEHICLE

"Totaled Vehicle" or "Totaled" as defined in Oregon law (ORS 801.527) means:

- A vehicle that is declared a total loss by an insurer who is obligated to cover the loss. Also, a vehicle that the insurer takes possession of or title to.
- A vehicle that has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80% of the retail market value prior to the damage. "Retail market value" is defined as the amount shown in publications used by financial institutions (e.g. banks, lenders) in this state.
- A vehicle that is stolen, if it is not recovered within 30 days of theft and the loss is not covered by an insurer. In this situation, you must notify DMV within 60 days of the theft.

▼ FOLLOW THESE INSTRUCTIONS IF YOUR VEHICLE IS TOTALED ▼

If your vehicle is totaled, in addition to completing the accident report, follow the instruction that is applicable to your case. **Either:**

1. SURRENDER the title to the insurer if the damage is covered by an insurer who declares the vehicle to be a "total loss," and the insurer takes possession of the vehicle; **or**
2. SURRENDER the title to DMV and apply for salvage title if the damage is covered by an insurer who declares the vehicle to be a "total loss," but you keep possession of the vehicle; **or**
3. SURRENDER the title to DMV and apply for salvage title if the damage was not covered by an insurer and the estimated cost of repair is at least 80% of the retail market value of the vehicle before the damage; **or**
4. NOTIFY DMV that your vehicle has been totaled if, for some reason, you are unable to obtain the title for surrender. You must provide DMV with a signed statement which includes:
 - A description of the vehicle which includes the year model, make, plate number and vehicle identification number.
 - A statement indicating the vehicle has been totaled.
 - A statement that you are unable to obtain the title and why.

DO NOT SUBMIT THE TITLE WITH THE ACCIDENT REPORT. You can obtain the salvage title application from any DMV office or by calling (503) 945-5000. If you have questions about salvage titles, call (503) 945-5122.

NOTE: It is a Class A misdemeanor with a penalty of imprisonment and/or fine if you fail to comply with the above requirements. (ORS 819.012)



OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Complete this form ONLY if your accident happened on a highway or premises open to the public, and resulted in any of the following: 1) More than \$1000 in damage to any one person's property; 2) Injury to any person (no matter how minor the injury); or, 3) the death of any person. (PLEASE PRINT - PRESS FIRMLY - FILL OUT BOTH SIDES)

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY	DO NOT WRITE IN THIS SPACE	Accident Number _____
ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route)			MILE POST		TYPE OF ACCIDENT - The accident involved one or more of the following: (Mark all that apply)
<input type="checkbox"/> WITHIN _____ FEET N S E W NAME OF NEAREST INTERSECTING ROAD <input type="checkbox"/> NEAR _____ MILES N S E W				<input type="checkbox"/> Two vehicles <input type="checkbox"/> ATV / Snowmobile <input type="checkbox"/> Overturned vehicle <input type="checkbox"/> More than two vehicles <input type="checkbox"/> Motorcycle <input type="checkbox"/> Animal _____ <input type="checkbox"/> Fatality <input type="checkbox"/> Motorized Scooter <input type="checkbox"/> Fixed object _____ <input type="checkbox"/> Bicycle <input type="checkbox"/> Train <input type="checkbox"/> Other _____ <input type="checkbox"/> Pedestrian <input type="checkbox"/> Parked vehicle	
<input type="checkbox"/> WITHIN _____ FEET N S E W NAME OF NEAREST CITY / TOWN <input type="checkbox"/> NEAR _____ MILES N S E W					

YOUR VEHICLE (No. 1)

Complete ALL of this section. If you fail to do so, your driving privileges may be suspended. You MUST list the insurance company that provided liability coverage for the vehicle you were driving.

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX	
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE	<input type="checkbox"/> IF ADDRESS CHANGE	
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE		
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE		
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

Was your vehicle's damage more than \$1000? YES NO

Other person's vehicle damage more than \$1000? YES NO

Did the accident occur while you were driving your employer's vehicle? YES NO

Were you driving on your job and being paid for the principal purpose of driving? YES NO

Were you being paid to drive and/or deliver persons or property? YES NO

Were you operating a government owned vehicle marked for transporting mail in accordance with government rules? YES NO

Were you operating an authorized emergency vehicle? YES NO

Were you operating a commercial motor vehicle requiring you to have a commercial driver license? YES NO

a) Were you transporting hazardous material? YES NO

Were occupants of the other vehicle(s) injured? YES NO

Did a police officer come to the scene? YES NO

If yes, name of police department: _____ City County State Police

Was a citation issued to you? YES NO

OTHER VEHICLE (No. 2)

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX	
DRIVER'S ADDRESS	CITY	STATE	ZIP CODE		
VEHICLE OWNER'S NAME AND ADDRESS <input type="checkbox"/> SAME	CITY	STATE	ZIP CODE		
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE		
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, ATTACH A SUPPLEMENTAL REPORT (Form 735-32B).

DESCRIBE WHAT HAPPENED:

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT X	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE # ()	DATE SIGNED
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YOU INTENDED TO...

Go straight ahead
 Make right turn
 Make left turn
 Make "U" turn
 Back-Up
 Enter driveway (also mark left or right turn)
 Remain stopped in traffic
 Enter parked position
 Slow or Stop
 Leave driveway (also mark left or right turn)
 Start in traffic lane
 Leave parked position
 Remain parked
 Overtake and pass

YOUR VEHICLE

Passenger car or van, pickup
 Any of the above and trailer
 Taxicab
 Bus
 Other publicly-owned vehicle
 Truck tractor & semi-trailer
 Farm tractor/farm equipment
 Military vehicle
 School bus
 Other _____
 Other truck combination
 Emergency vehicle
 Motorcycle
 Motor-scooter/bike
 Truck/truck tractor

WEATHER CONDITIONS

Clear
 Raining
 Snowing
 Fog
 Other

ROAD SURFACE

Dry
 Wet
 Snowy
 Icy
 Other

LIGHT CONDITIONS

Daylight
 Dawn or dusk
 Darkness (lighted)
 Darkness (unlighted)
 Other

YOUR RESIDENCE

Local resident (within 25 miles of accident site)
 Residing elsewhere in state
 Non-resident of this state:
 College student
 Military
 Temporary job

YOU WERE HEADED

North East
 South West

On: _____
 (name of street, road or route)

OTHER DRIVER WAS HEADED

North East
 South West

On: _____
 (name of street, road or route)

WITNESS INFORMATION:

If this accident involved a pedestrian or bicyclist, complete the following:

PEDESTRIAN NAME BICYCLIST NAME

Pedestrian or bicyclist was going:
 N S E W

ALONG OR ACROSS: (name of street, road or route)

From: _____

To: _____

EXAMPLE: (From: NE corner To: SE corner (or) From: East side To: West side, etc.)

Sex and age of pedestrian / bicyclist:
 Male Female Age: _____

Extent of pedestrian / bicyclist injury:
 Deceased Possible injury
 Incapacitated No apparent injury
 Visible injury

Pedestrian / bicyclist action: (mark one)
 Crossing at intersection or crosswalk
 Crossing **not** at intersection or crosswalk
 Walking / riding in roadway with traffic
 Walking / riding in roadway **against** traffic
 Standing in roadway
 Pushing or working on vehicles in roadway
 Other working in road
 Playing in road
 Hitchhiking
 Not in roadway
 Other _____ (specify)

DRIVER AND PASSENGER INJURY AND SAFETY EQUIPMENT INFORMATION

SAFETY EQUIPMENT CODES
 WRITE (in column C)

▼

0 No seat belt available
 1 Seat belt available but NOT used
 2 Seat belt available and in use
 3 Child restraint device available
 4 Child restraint device in use
 5 Helmet NOT in use
 6 Helmet in use
 7 Air bag deployed
 8 Air bag available - NOT deployed
 9 Air bag NOT available

INJURY CODE FOR OCCUPANTS
 WRITE (in column D)

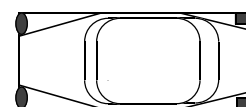
▼

1 Deceased as a result of the accident
 2 Incapacitated - unconscious, could not walk, broken or distorted limbs, etc.
 3 Visible injury - lump, abrasion cuts
 4 Momentary unconsciousness, complaint of pain, nausea, limping
 5 No apparent injury

SEAT POSITION	PASSENGER'S NAMES (your vehicle)	C				D
		A	B	SFTY EOP	AIR BAG	
DRIVER		SEX	AGE		INJURY	
FRONT CENTER						
FRONT RIGHT						
MIDDLE * LEFT						
MIDDLE * CENTER						
MIDDLE * RIGHT						
REAR LEFT						
REAR CENTER						
REAR RIGHT						

* Use only for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

Vehicle Damage

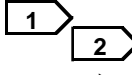
FRONT 


USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)


Vehicle towed
 Rollover
 Under car
 Totaled
 Unknown

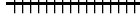
Your Vehicle (No. 1) damage: \$ _____
 Other Vehicle (No. 2) damage: \$ _____

Diagram

Number each vehicle: 

Show path by: 

Show pedestrian/bicyclist by: 

Show railroad tracks by: 

_____ (name of street, road or route) ↑

_____ (name of street, road or route) ↑



INSURANCE VERIFICATION REQUEST

ACCIDENT DATE	DAY OF WEEK M T W T H F S S N	TIME OF DAY AM PM	COUNTY	DO NOT WRITE IN THIS SPACE	Accident Number _____
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YOUR VEHICLE (No. 1)

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VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE		
<input type="checkbox"/> SAME					
INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS	CITY	STATE	ZIP CODE		
POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

INSTRUCTIONS TO INSURANCE COMPANY

1. If the accident described above was not covered by liability insurance as indicated, check reason below and return this form dated and signed to the address below.
2. If indicated coverage was in effect at the time of the accident no action is required.

REASON FOR DENIAL:

- Policy Expired Before Accident
- Policy Effective After Accident
- Vehicle Not Covered on Policy
- Policy Number Given is Incorrect
- Lapse in Policy
- Other: _____

PRINTED NAME OF AUTHORIZED INSURANCE REPRESENTATIVE	SIGNATURE OF AUTHORIZED INSURANCE REPRESENTATIVE X	DATE OF DENIAL
PHONE NUMBER	FAX NUMBER	CLAIM NUMBER

ACCIDENT REPORTING UNIT
 DRIVER AND MOTOR VEHICLE SERVICES
 1905 LANA AVENUE NE
 SALEM OR 97314