SECTION A

Report of Accidents. The driver of a vehicle involved in an accident resulting in injury to or death of any person, or damage to property of any one person in excess of five hundred dollars ($500) shall within ten days after such accident forward a written report of such accident TO: NJ DEPARTMENT OF TRANSPORTATION, 1035 PARKWAY AVENUE, P.O. BOX 600, TRENTON, NJ 08625-0600 ATTN: BUREAU OF SAFETY PROGRAMS, THIOKOL BLDG. #8. Failure to report will result in the suspension of both driving and registration privileges. Under Chapter 4 of Title 39 these reports are not available for public information nor are they admissible in evidence for any other purpose in a proceeding or action arising out of the accident. They are solely for the use of the Department of Transportation in developing information useful in the prevention of accidents and for compliance with the Motor Vehicle Security Responsibility and Compulsory Insurance Laws. "A written report of an accident shall not be required if a law enforcement officer submits a written report of the accident to the division pursuant to R.S. 39:4-131."

INSTRUCTIONS
PLEASE PRINT OR TYPE
ALL INFORMATION
USE BLACK OR DARK BLUE INK

Begin by folding along this line
Follow the instructions at the top of Section B.
Numbered arrows should point to
boxes on reverse side after folding.

1. Give exact date of accident.
2. If a vehicle is unoccupied, enter all available information. Be sure to enter the correct vehicle plate number.
3. Driver information must be entered exactly as it appears on each driver's license.
4. Owner information must be entered exactly as it appears on the registration certificate of each vehicle involved in the accident.
5. If you were involved in an accident in which there were more than two vehicles, an additional one of these report forms must be filled out. On that form, place the information for the third vehicle in the space marked "Your Vehicle No. 1" and mark it No. 3. Use the space marked "Other Vehicle No. 2" for the fourth vehicle, and mark it No. 4 and so on.
6. The location of the accident is very important and you should describe it as accurately as possible in the space provided.
7. For each person injured complete boxes 67, 68, 69, 70, 71 and list names and addresses.
8. If there are more than two persons injured, another one of these report forms is needed. In the injury section of that report, record the required information for all additional injured persons.
9. Attach any additional report forms to page one. Each page of the report must be numbered in the upper right corner, dated and SIGNED on the bottom line.
10. Answer all questions to the best of your knowledge.
11. Send all reports to:

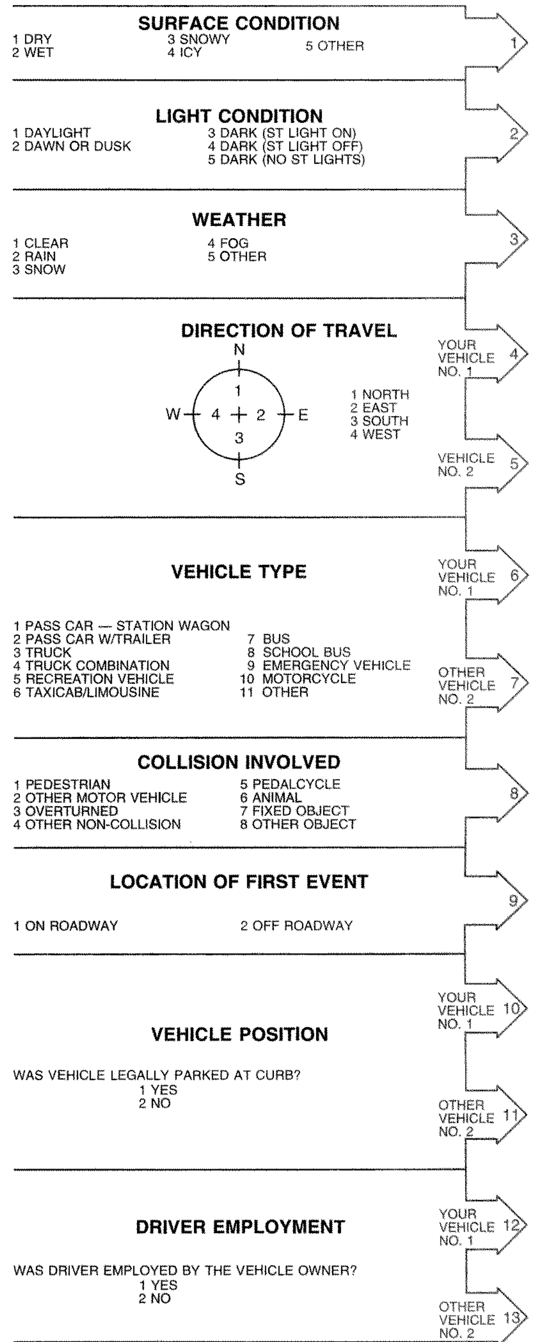
NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
P.O. BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF SAFETY PROGRAMS
THIOKOL BLDG. #8

FOLD ALONG THIS LINE

SECTION B

REPORT OF MOTOR VEHICLE ACCIDENT

Be sure form is folded along this line before answering the questions below.
Numbered arrows should point to boxes on reverse side after folding.
Fill in the 13 boxes to the right by entering the number of the item which best describes the circumstances of the accident.
If a question does not apply enter a dash (—).
If an answer is unknown enter a "U".



SURFACE CONDITION
1 DRY 2 WET 3 SNOWY 4 ICY 5 OTHER — 1

LIGHT CONDITION
1 DAYLIGHT 2 DAWN OR DUSK 3 DARK (ST LIGHT ON) 4 DARK (ST LIGHT OFF) 5 DARK (NO ST LIGHTS) — 2

WEATHER
1 CLEAR 2 RAIN 3 SNOW 4 FOG 5 OTHER — 3

DIRECTION OF TRAVEL
N, W, E, S (1, 2, 3, 4)
1 NORTH 2 EAST 3 SOUTH 4 WEST
YOUR VEHICLE NO. 1 — 4
VEHICLE NO. 2 — 5

VEHICLE TYPE
1 PASS CAR — STATION WAGON
2 PASS CAR W/TRAILER
3 TRUCK
4 TRUCK COMBINATION
5 RECREATION VEHICLE
6 TAXICAB/LIMOUSINE
7 BUS
8 SCHOOL BUS
9 EMERGENCY VEHICLE
10 MOTORCYCLE
11 OTHER
YOUR VEHICLE NO. 1 — 6
OTHER VEHICLE NO. 2 — 7

COLLISION INVOLVED
1 PEDESTRIAN
2 OTHER MOTOR VEHICLE
3 OVERTURNED
4 OTHER NON-COLLISION
5 PEDALCYCLE
6 ANIMAL
7 FIXED OBJECT
8 OTHER OBJECT
— 8

LOCATION OF FIRST EVENT
1 ON ROADWAY 2 OFF ROADWAY — 9

VEHICLE POSITION
WAS VEHICLE LEGALLY PARKED AT CURB?
1 YES
2 NO
YOUR VEHICLE NO. 1 — 10
OTHER VEHICLE NO. 2 — 11

DRIVER EMPLOYMENT
WAS DRIVER EMPLOYED BY THE VEHICLE OWNER?
1 YES
2 NO
YOUR VEHICLE NO. 1 — 12
OTHER VEHICLE NO. 2 — 13

Please Read Instructions 1 Through 11 On other Side of Fold Before Completing The inside of Report.

DO NOT FILL IN

FOR USE OF INSURANCE COMPANY ONLY
Instructions for Insurance Company

With regard to an automobile liability insurance policy for the policyholder named on the reverse side hereof, the undersigned insurance company advises you in accordance with the items checked below:

☐ 1. No policy was in effect on the date of the accident.
☐ 2. Our policy for the named policyholder applies to him as the operator but it does not apply to the owner of the vehicle involved in the accident.
☐ 3. Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident.
☐ 4. Other; explain.

NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
P.O. BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF SAFETY PROGRAMS
THIOKOL BLDG. #8

Name of Insurance Company

MUST be signed by Authorized Representatives

NEW JERSEY MOTOR VEHICLE COMMISSION
MOTOR VEHICLE ACCIDENT REPORT

Follow Instructions on other side

ACCIDENT DATE MO. | DAY | YEAR | 15 DAY OF WK. | 16 TIME ☐ AM ☐ PM | 17 NUMBER OF VEHICLES | 18 NUMBER KILLED | 19 NUMBER INJURED | 20 DID POLICE INVESTIGATE ACCIDENT? ☐ YES ☐ NO | 21 NAME OF POLICE AGENCY

LOCATION OF ACCIDENT (MUNICIPALITY)

23 ROUTE NUMBER OR NAME OF STREET

24 IF NOT AT INTERSECTION COLLISION WAS BETWEEN:

ROAD 1 ______

ROAD 2 ______

DISTANCE FROM ROAD 1 ______

COUNTY

26 INTERSECTING STREET, ROAD OR RAILROAD

Your ehicle No. 1

27 INSURANCE COMPANY

28 POLICY NO.

DRIVER'S FIRST NAME | INITIAL | LAST NAME

NUMBER AND STREET

CITY | STATE | ZIP CODE

DRIVERS LICENSE NUMBER | 33 STATE | 34 BIRTHDATE MO. | DAY | YEAR | 35 EYE COLOR | 36 SEX

OWNER'S FIRST NAME | INITIAL | LAST NAME ☐ SAME AS DRIVER

NUMBER AND STREET

CITY | STATE | ZIP CODE

MAKE OF VEHICLE | 41 YEAR | 42 LICENSE PLATE NO. | 43 STATE

Other Vehicle No. 2

44 INSURANCE COMPANY

45 POLICY NO.

46 DRIVER'S FIRST NAME | INITIAL | LAST NAME

47 NUMBER AND STREET

48 CITY | STATE | ZIP CODE

49 DRIVERS LICENSE NUMBER | 50 STATE | 31 BIRTHDATE MO. | DAY | YEAR | 52 EYE COLOR | 53 SEX

54 OWNER'S FIRST NAME | INITIAL | LAST NAME ☐ SAME AS DRIVER

55 NUMBER AND STREET

56 CITY | STATE | ZIP CODE

57 MAKE OF VEHICLE | 58 YEAR | 59 LICENSE PLATE NO. | 60 STATE

1 2 3 4 5 6 7 8 9 10 11 12 13

DESCRIBE DAMAGE TO VEH. NO. 1

ST. COST TO REPAIR

62 CIRCLE ONE OF THE 8 DIAGRAMS BELOW IF IT ADEQUATELY DESCRIBES THE ACCIDENT OR DRAW YOUR OWN DIAGRAM IN THE SPACE TO THE RIGHT

1. REAR END	5. RIGHT TURN
2. OVERTAKING	6. RIGHT TURN
3. LEFT TURN	7. READ ON
4. INTERSEC-ION	8. SIDESWIPE

63 9

DIAGRAM

INDICATE NORTH

64 DESCRIBE DAMAGE TO VEH. NO. 2

EST. COST TO REPAIR

JURED LOCATED
N VEH. 1 B ON A PEDALCYCLE O OTHER
N VEH. 2 P PEDESTRIAN

65 ACCIDENT DESCRIPTION

POSITION IN/ON VEHICLE
1 DRIVER 2 THRU 7 PASSENGERS
8 RIDING/HANGING ON OUTSIDE

VICTIM'S PHYSICAL CONDITION
1 KILLED
2 INCAPACITATED
3 MODERATE INJURY
4 COMPLAINT OF PAIN

66 DESCRIBE DAMAGE TO PROPERTY OTHER THAN VEHICLE (GIVE OWNER'S NAME AND ADDRESS AND EST. COST TO REPAIR)

67 | 68 | 69 | 70 AGE | 71 SEX | **Injury Section: Fill Out Space Below for Every Person Injured or Killed in the Accident.**

NAME AND ADDRESS OF INJURED

NATURE OF INJURY

NAME AND ADDRESS OF INJURED

NATURE OF INJURY

SIGN HERE **Date of Report**

FILL IN BUT DO NOT DETACH

NEW JERSEY SR-21

If you fail to give full information below, it will be assumed that you did not have automobile liability insurance.

Fill in this form with information from your insurance policy. All information will be verified with the insurance company.

ME OF INSURANCE COMPANY COVERING YOU FOR LIABILITY FOR DAMAGE OR INJURY TO OTHERS (NOT AGENT)

ME AND ADDRESS OF INSURANCE AGENT WHO SOLD YOU POLICY