

# VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

|  |  |         |                   |                   |                                     |                                       |   |       |     |     |
|--|--|---------|-------------------|-------------------|-------------------------------------|---------------------------------------|---|-------|-----|-----|
| CLAIMANT AND INCIDENT INFORMATION      | CLAIMANT'S NAME <b>(A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)</b>                 |         |                   |                   | DATE OF ACCIDENT(mm/dd/yyyy)        |                                       | TIME<br>AM <input type="checkbox"/> PM <input type="checkbox"/> |       |     |     |
|  | CURRENT STREET (RESIDENCE) ADDRESS   |         |                   | CITY              | STATE                               | ZIP                                   | PHONE HOME WORK   |       |     |     |
|  | (RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT                              |         |                   | CITY              | STATE                               | ZIP                                   | EMAIL   |       |     |     |
|  | State/County/City (if applicable) where occurred   |         | STREET OR HWY     | MILEPOST NO.      | INTERSECTION OR NEAREST STREET/ROAD |                                       |   |       |     |     |
| YOUR VEHICLE INFORMATION (VEHICLE #1)  | YEAR   | MAKE    | MODEL             | LICENSE PLATE NO. | WHERE CAN CAR BE SEEN?              |                                       | WHEN?   |       |     |     |
|  | NAME OF VEHICLE OWNER  |         | ADDRESS           |                   | CITY                                | HOME AND WORK PHONE                   |   |       |     |     |
|  | NAME OF DRIVER   |         | ADDRESS           |                   | CITY                                | HOME AND WORK PHONE                   |   |       |     |     |
|  | DRIVER'S LICENSE NUMBER  |         | STATE OF ISSUANCE |                   | DATE OF EXPIRATION                  |                                       |   |       |     |     |
|  | DESCRIBE DAMAGE  |         |                   |                   | ESTIMATE \$                         | YOUR INSURANCE COMPANY AND POLICY NO. |   |       |     |     |
| OTHER VEHICLE INFORMATION (VEHICLE #2) | YEAR   | MAKE    | MODEL             | LICENSE PLATE NO. | STATE AGENCY, IF KNOWN              |                                       |   |       |     |     |
|  | NAME OF OWNER  |         | ADDRESS           |                   | CITY                                | PHONE                                 |   |       |     |     |
|  | NAME OF DRIVER   |         | ADDRESS           |                   | CITY                                | PHONE                                 |   |       |     |     |
|  | DESCRIBE DAMAGE  |         |                   |                   |                                     |                                       | ESTIMATE \$   |       |     |     |
| OTHER NON-VEHICLE DAMAGE               | WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED. |         |                   |                   |                                     |                                       |   |       |     |     |
|  | NAME OF OWNER  |         | ADDRESS           |                   | CITY                                | PHONE                                 |   |       |     |     |
|  | DESCRIBE DAMAGE  |         |                   |                   |                                     |                                       | ESTIMATE \$   |       |     |     |
| INJURED PARTIES                        | NAME   | ADDRESS | PHONE             | INJURY            | AGE                                 | VEH 1                                 | VEH 2   | VEH 3 | PED | OTH |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
| WITNESSES                              | NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)   |         | ADDRESS           | CITY              | PHONE                               |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |
|  | HOME WORK  |         |                   |                   |                                     |                                       |   |       |     |     |

**COMPLETE ALL DETAILS**

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

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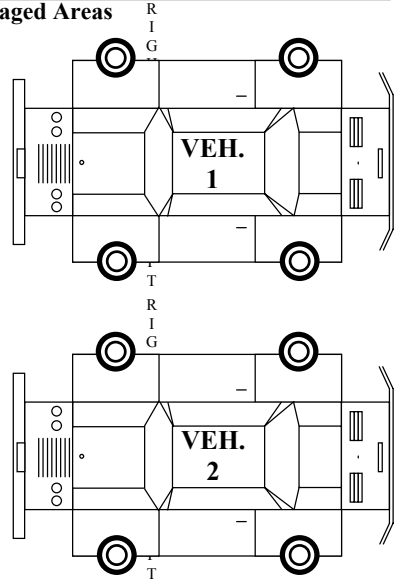


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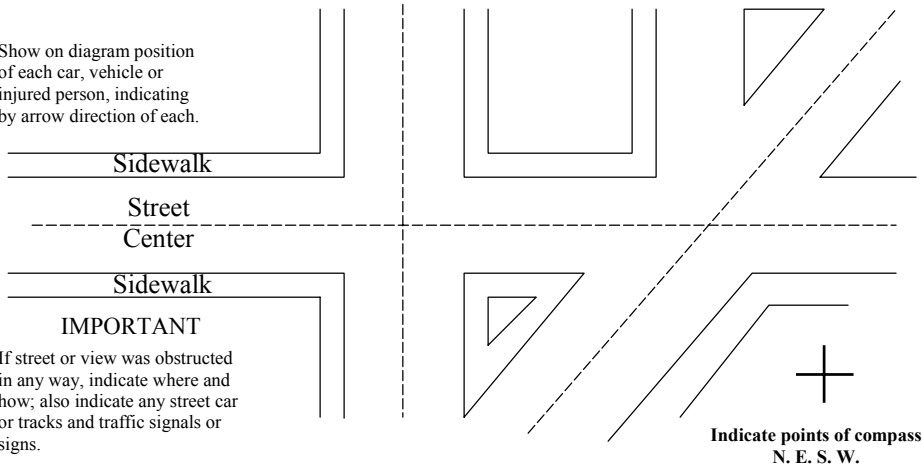


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- |   |                                    |  |                           |
|---|------------------------------------|--|---------------------------|
| <input type="checkbox"/> Straight Road  | <input type="checkbox"/> Hillcrest | <input type="checkbox"/> One Lane              | <b>Mark Damaged Areas</b> |
| <input type="checkbox"/> Curve – R or L | <input type="checkbox"/> Uphill    | <input type="checkbox"/> One and One-Half Lane |                           |
| <input type="checkbox"/> Level          | <input type="checkbox"/> Downhill  | <input type="checkbox"/> Two Lane or Four Lane |                           |



Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.



**IMPORTANT**  
If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass  
N. E. S. W.

| LIGHT CONDITIONS (CHECK ONE)                      | TRAFFIC CONTROL  | TYPE OF ROAD (CHECK ONE OR MORE)  | VEHICLE CONDITION (CHECK ONE OR MORE)  | ROAD SURFACE (CHECK ONE)  | WEATHER (CHECK ONE)                                 |
|---|--|---|--|---|---|
| 1 <input type="checkbox"/> DAYLIGHT               | VEHICLE NO. 1 NO. 2  | VEHICLE NO. 1 NO. 2   | VEHICLE NO. 1 NO. 2  | VEHICLE NO. 1 NO. 2   | 1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST |
| 2 <input type="checkbox"/> DAWN                   | <input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS            | <input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY                 | <input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES         | <input type="checkbox"/> 1 <input type="checkbox"/> DRY             | 2 <input type="checkbox"/> RAINING                  |
| 3 <input type="checkbox"/> DUSK                   | <input type="checkbox"/> 2 <input type="checkbox"/> STOP SIGN          | <input type="checkbox"/> 2 <input type="checkbox"/> TWO WAY                 | <input type="checkbox"/> 2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS     | <input type="checkbox"/> 2 <input type="checkbox"/> WET             | 3 <input type="checkbox"/> SNOWING                  |
| 4 <input type="checkbox"/> DARK STREET LIGHTS ON  | <input type="checkbox"/> 3 <input type="checkbox"/> FLASHING RED       | <input type="checkbox"/> 3 <input type="checkbox"/> REVERSIBLE ROAD         | <input type="checkbox"/> 3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS    | <input type="checkbox"/> 3 <input type="checkbox"/> SNOW            | 4 <input type="checkbox"/> FOG                      |
| 5 <input type="checkbox"/> DARK STREET LIGHTS OFF | <input type="checkbox"/> 4 <input type="checkbox"/> FLASHING AMBER     | <input type="checkbox"/> 4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP  | <input type="checkbox"/> 4 <input type="checkbox"/> TIRES WORN               | <input type="checkbox"/> 4 <input type="checkbox"/> ICE             | 5 <input type="checkbox"/> OTHER (SPECIFY)          |
| 6 <input type="checkbox"/> DARK NO STREET LIGHT   | <input type="checkbox"/> 5 <input type="checkbox"/> RR SIGNAL          | <input type="checkbox"/> 5 <input type="checkbox"/> ALLEY                   | <input type="checkbox"/> 5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES | <input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY) |   |
| 7 <input type="checkbox"/> OTHER (SPECIFY)        | <input type="checkbox"/> 6 <input type="checkbox"/> OFFICER/FLAGMAN    | <input type="checkbox"/> 6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES | <input type="checkbox"/> 6 <input type="checkbox"/> OTHER (SPECIFY)          |   |   |
|   | <input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN         | <input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED               |  | NAME OF INVESTIGATING POLICE AGENCY:<br>_____                       |   |
|   | <input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL | <input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED                 |  | INVESTIGATING AGENCY REPORT NO.<br>_____                            |   |
|   | <input type="checkbox"/> 9 <input type="checkbox"/> OTHER              | <input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED               |  |   |   |

"  
**A separate claim form should be submitted for each claimant**

This information is being provided to aid in resolving the claim.

*I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.*

\_\_\_\_\_  
*Signature of Claimant*

\_\_\_\_\_  
*Date and Place (residential address, city and county)*