

Accident Number		Agency NCIC No.		GEORGIA UNIFORM MOTOR VEHICLE ACCIDENT REPORT				County		Date Rec. by DMVS		
Date	Day of Week <input type="checkbox"/> Sun <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> S			Time	Off. Arrived	Vehicles	Total Number of: Injuries Fatalities		Inside City Of:			
Road of Occurrence _____ 1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St.				At Its Intersection With _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St.				Corrected Report? Yes <input type="checkbox"/>		Suppl. To Original? Yes <input type="checkbox"/>		Hit and Run? Yes <input type="checkbox"/>
Not At Its Intersection But _____ <input type="checkbox"/> Miles 1 <input type="checkbox"/> North 3 <input type="checkbox"/> East <input type="checkbox"/> Feet 2 <input type="checkbox"/> South 4 <input type="checkbox"/> West				Of: _____ 1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> city St. 5 <input type="checkbox"/> Co. Line				And continuing in the direction checked above, the Next Reference Point is _____ 1 <input type="checkbox"/> Interstate 2 <input type="checkbox"/> Lowest St. Rt. 3 <input type="checkbox"/> Co. Road 4 <input type="checkbox"/> City St. 5 <input type="checkbox"/> Co. Line				
Driver #	LAST NAME	FIRST	MIDDLE	Driver #	LAST NAME	FIRST	MIDDLE					
Ped # <input type="checkbox"/>	Address			Ped # <input type="checkbox"/>	Address							
City	State	Zip	DOB	City	State	Zip	DOB					
Driver's License No.	Class	State	<input type="checkbox"/> Male <input type="checkbox"/> Female	Driver's License No.	Class	State	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Posted Speed	Insurance Co.	Policy No.		Posted Speed	Insurance Co.	Policy No.						
Year	Make	Model	Telephone No.	Year	Make	Model	Telephone No.					
VIN	Vehicle Color			VIN	Vehicle Color							
Tag #	State	County	Year	Tag #	State	County	Year					
Trailer Tag #	State	County	Year	Trailer Tag #	State	County	Year					
<input type="checkbox"/> Same as Driver	Owner's Last Name	First	Middle	<input type="checkbox"/> Same as Driver	Owner's Last Name	First	Middle					
Address				Address								
City	State	Zip		City	State	Zip						
Removed By	<input type="checkbox"/> Request <input type="checkbox"/> List			Removed By	<input type="checkbox"/> Request <input type="checkbox"/> List							
Alcohol Test	Type	Results	Drug Test	Type	Results	Alcohol Test	Type	Results	Drug Test	Type	Results	
Driver Cond	Direction Of Travel	Vision Obscured	Contributing Factors	Driver Cond	Direction Of Travel	Vision Obscured	Contributing Factors	Driver Cond	Direction Of Travel	Vision Obscured	Contributing Factors	
Veh Cond	Veh Maneuver	Ped. Maneuver		Veh Cond	Veh Maneuver	Ped. Maneuver		Veh Cond	Veh Maneuver	Ped. Maneuver		
Most Harmful Event	Veh Class:	Veh Type:		Most Harmful Event	Veh Class:	Veh Type:						
Traffic Ctrl	Device Inoperative? <input type="checkbox"/> Yes <input type="checkbox"/> No			Traffic Ctrl	Device Inoperative? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Injured Taken To: _____				By: _____								
EMS Notified Time	EMS Arrival Time	Hospital Arrival Time	Photos Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No	By: _____								
Report By:	Department	Report Date	Checked By:	Date Checked								
Witness(es): Name	Address	City	State	Zip Code	Telephone No.							
DMVS MICROFILM NUMBER (DO NOT WRITE IN THIS SPACE)												
COMMERCIAL VEHICLES ONLY												
Carrier Name				Carrier Name								
Vehicle #				Vehicle #								
Address	State	Zip	Address	State	Zip	Address	State	Zip	Address	State	Zip	
No. of Axles	G.V.W.R.	Fed. Reportable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Cargo Body Type	No. of Axles	G.V.W.R.	Fed. Reportable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Cargo Body Type	No. of Axles	G.V.W.R.	Fed. Reportable 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Cargo Body Type	
Vehicle Config.	I.C.C.M.C. #	U.S. D.O.T. #	Interstate <input type="checkbox"/> Intrastate <input type="checkbox"/>	Vehicle Config.	I.C.C.M.C. #	U.S. D.O.T. #	Interstate <input type="checkbox"/> Intrastate <input type="checkbox"/>	Vehicle Config.	I.C.C.M.C. #	U.S. D.O.T. #	Interstate <input type="checkbox"/> Intrastate <input type="checkbox"/>	
C.D.L.? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	C.D.L. Suspended? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Vehicle Placarded? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hazardous Materials? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Released? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	C.D.L.? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	C.D.L. Suspended? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Vehicle Placarded? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hazardous Materials? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Released? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	C.D.L.? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	C.D.L. Suspended? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
If YES, Name or 4 Digit Number from Diamond or Box: _____				If YES, Name or 4 Digit Number from Diamond or Box: _____								
1 Digit Number from Bottom of Diamond: _____				1 Digit Number from Bottom of Diamond: _____								
__ Ran Off Road __ Down Hill Runaway __ Cargo Loss or Shift __ Separation of Units				__ Ran Off Road __ Down Hill Runaway __ Cargo Loss or Shift __ Separation of Units								

