In this Accident Report Packet you will find the following documents:

- **At the Scene of an Accident Form**
- **Witness Cards** (orange card)
- **Insurance Identification Card** (Proof of Insurance – blue card)
- **Unattended Vehicle Card** (yellow card)
- **Auto Accident Report Form**
- **Employee Status Report**
- **DMV Oregon Traffic Accident and Insurance Report**

In the event of an accident:

- Assess the situation and call for the police.
- Contact the police or 911 when necessary.
  - DO NOT move an injured person.
- Light and place emergency flares if necessary *(found in vehicle’s emergency kit).*
- Request that any responding law enforcement officer file a written report, regardless of the extent of the damages.
- Move the vehicle only when directed to do so or if possible avoid obstructing traffic.

At the scene of the accident:

- Collect the other drivers’ information using the **At the Scene of an Accident Form**.
- Show the blue **Insurance Identification Card** (Proof of Insurance) to the police and any other parties that may request that information.
- Provide witnesses with the orange **Witness Cards**.
- If the accident involved an unattended vehicle, fill out the yellow **Unattended Vehicle Card** and leave it on the unattended vehicle.

When it is safe to do so:

- Report the accident to University Motor Pool at (866) 253-5671 and Risk Management at (541) 737-7350.
- Fill out the **Auto Accident Report Form** and return to University Motor Pool and Risk Management within 24 hours.
- You must file an **Oregon Traffic Accident and Insurance Report** with DMV within 72 hours when: Damage to any vehicle is over $2,500; Any vehicle is towed from the scene; Injury or death resulted from this accident; or Damages to anyone’s property other than a vehicle involved in this accident is more than $2,500. **It is your responsibility to send the original form to the DMV.**

In the event of an employee injury:

- Report the injury to your supervisor. Supervisor shall enter an HR **Advocate Report** *(risk.oregonstate.edu/workerscomp).*
- If medical attention is sought, you and your supervisor shall complete the SAIF 801 *(risk.oregonstate.edu/workerscomp)* and your doctor shall complete an **Employee Status Report** (enclosed).

**IMPORTANT:**

- **DO NOT** debate or admit responsibility.
- **DO NOT** make statements to anyone except: police/law enforcement, your supervisor, University Motor Pool, Risk Management, or Legal Counsel.
# AT THE SCENE OF AN ACCIDENT FORM

**Take Pictures of Damage**

<table>
<thead>
<tr>
<th><strong>OSU DRIVER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE AND TIME OF ACCIDENT</strong></td>
</tr>
<tr>
<td><strong>MAKE/MODEL/PLATE # OF OSU VEHICLE</strong></td>
</tr>
<tr>
<td><strong>LOCATION OF ACCIDENT</strong></td>
</tr>
</tbody>
</table>

## OTHER VEHICLE INFORMATION

<table>
<thead>
<tr>
<th><strong>DRIVER’S NAME</strong></th>
<th><strong>PHONE #</strong></th>
<th><strong>ADDRESS</strong></th>
<th><strong>STATE</strong></th>
<th><strong>ZIP CODE</strong></th>
<th><strong>YEAR OF VEHICLE</strong></th>
<th><strong>LICENSE PLATE #</strong></th>
<th><strong>STATE</strong></th>
<th><strong>DRIVER’S LICENSE #</strong></th>
<th><strong>ESTIMATED DAMAGE TO VEHICLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INSURANCE CO.</strong></td>
<td><strong>POLICY #</strong></td>
<td><strong>INSURANCE CO. ADDRESS</strong></td>
<td><strong>INSURANCE CO. STATE AND ZIP CODE</strong></td>
<td><strong>INSURANCE CO. PHONE #</strong></td>
<td><strong>INJURIES, IF ANY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ADDITIONAL VEHICLE INFORMATION (If applicable)

<table>
<thead>
<tr>
<th><strong>DRIVER’S NAME</strong></th>
<th><strong>PHONE #</strong></th>
<th><strong>ADDRESS</strong></th>
<th><strong>STATE</strong></th>
<th><strong>ZIP CODE</strong></th>
<th><strong>YEAR OF VEHICLE</strong></th>
<th><strong>LICENSE PLATE #</strong></th>
<th><strong>STATE</strong></th>
<th><strong>DRIVER’S LICENSE #</strong></th>
<th><strong>ESTIMATED DAMAGE TO VEHICLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INSURANCE CO.</strong></td>
<td><strong>POLICY #</strong></td>
<td><strong>INSURANCE CO. ADDRESS</strong></td>
<td><strong>INSURANCE CO. STATE AND ZIP CODE</strong></td>
<td><strong>INSURANCE CO. PHONE #</strong></td>
<td><strong>INJURIES, IF ANY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PASSENGERS IN OTHER VEHICLE

(Use back of page to list additional passengers info)

<table>
<thead>
<tr>
<th><strong>NAME</strong></th>
<th><strong>PHONE #</strong></th>
<th><strong>ADDRESS</strong></th>
<th><strong>STATE</strong></th>
<th><strong>ZIP CODE</strong></th>
<th><strong>INJURIES, IF ANY</strong></th>
</tr>
</thead>
</table>

## PASSENGERS IN ADDITIONAL VEHICLE

(Use back of page to list additional passengers info)

<table>
<thead>
<tr>
<th><strong>NAME</strong></th>
<th><strong>PHONE #</strong></th>
<th><strong>ADDRESS</strong></th>
<th><strong>STATE</strong></th>
<th><strong>ZIP CODE</strong></th>
<th><strong>INJURIES, IF ANY</strong></th>
</tr>
</thead>
</table>

Use the information on this sheet to complete the Auto Accident Report Form (online at risk.oregonstate.edu) and, if applicable, the DMV Oregon Traffic Accident and Insurance Report.

Please return completed form to: OSU Risk Management
3015 SW Western Blvd
208 Oak Creek Building
Corvallis, OR 97333
(541) 737-7350
risk@oregonstate.edu
Use this page to list the information of additional passengers.

<table>
<thead>
<tr>
<th>PASSENGERS IN OTHER VEHICLE</th>
<th>PASSENGERS IN ADDITIONAL VEHICLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME</strong></td>
<td><strong>PHONE #</strong></td>
</tr>
<tr>
<td><strong>ADDRESS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>STATE</strong></td>
<td><strong>ZIP CODE</strong></td>
</tr>
<tr>
<td><strong>INJURIES, IF ANY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NAME</strong></td>
<td><strong>PHONE #</strong></td>
</tr>
<tr>
<td><strong>ADDRESS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>STATE</strong></td>
<td><strong>ZIP CODE</strong></td>
</tr>
<tr>
<td><strong>INJURIES, IF ANY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NAME</strong></td>
<td><strong>PHONE #</strong></td>
</tr>
<tr>
<td><strong>ADDRESS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>STATE</strong></td>
<td><strong>ZIP CODE</strong></td>
</tr>
<tr>
<td><strong>INJURIES, IF ANY</strong></td>
<td></td>
</tr>
</tbody>
</table>
WITNESS CARD

Under ORS 811.715 as a witness of a traffic accident, you are obligated to provide your name and address.

To be completed by the Witness

<table>
<thead>
<tr>
<th>Accident Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ___________ Time: ___________</td>
</tr>
<tr>
<td>Accident Location:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witness Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ___________________</td>
</tr>
<tr>
<td>Address: ___________________</td>
</tr>
<tr>
<td>City: _______________ State: _______________</td>
</tr>
<tr>
<td>Phone #: ___________________</td>
</tr>
</tbody>
</table>

To be completed by OSU Driver

| Driver's Name: ___________________ |
| Department: ___________________ |
| Phone Number: ___________________ |

Please return the Witness Card to the OSU in the mailbox (postage is pre-paid). Thank you!

OSU Risk Management
3015 SW Western Blvd
130 Oak Creek Building
Corvallis, OR 97333
(541) 737-7350
risk@oregonstate.edu
OR

INSURANCE IDENTIFICATION CARD

COMPANY NUMBER       COMPANY
                      Self-Insured

POLICY NUMBER EFFECTIVE DATE EXPIRATION DATE

YEAR MAKE/MODEL VEHICLE IDENTIFICATION NUMBER
Fleet All Owned Leased or Rented Vehicles

AGENCY/COMPANY ISSUING CARD
Brown & Brown Northwest
601 SW 2nd Avenue, Ste. 1200
Portland OR 97204 (800)344-5581

INSURED
Oregon State University
3015 SW Western Blvd
Corvallis OR 97333
OSU Claims Phone# 541-737-7252

SEE IMPORTANT NOTICE ON REVERSE SIDE

THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the following information:

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

Every driver shall have in his or her possession while operating a motor vehicle, and shall produce on demand proof of insurance covering the vehicle being operated. Failure to produce the required proof of insurance can result in a misdemeanor conviction. It is unlawful for any person to display, cause or permit the display of, or have in possession proof of insurance that is fictitious or fraudulent. In addition to criminal penalties, any person convicted of a misdemeanor because of any of the above is subject to drivers license revocation, and a fine of not less than $200.
### OSU Driver Contact

- **Name**: 
- **Driver’s License #**: 
- **Dept.**: 
- **Dept. Phone**: 
- **OSU Vehicle Make/Model & Plate #**: 

### OSU Vehicle Insurance Information

- **Unattended Vehicle Make/Model & Plate #**: 

### Brief Description of Incident

- 
- 
- 

---

**To File a Claim, contact**

OSU Risk Management  
3015 SW Western Blvd.  
130 Oak Creek Building  
Corvallis, OR 97333  
(541) 737-7350  
risk@oregonstate.edu
# Auto Accident Report Form

*Take Pictures of Damage*

Return Completed form to University Motor Pool and Risk Management within 24 hours
Motor Pool: (866) 253-5671, motorpool@oregonstate.edu; Risk Management: (541) 737-7350, risk@oregonstate.edu

## ACCIDENT INFORMATION

<table>
<thead>
<tr>
<th>Date of Accident</th>
<th>Time of Day</th>
<th>County/State</th>
<th>Location (Cross Streets)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Police Response</th>
<th>Police Report #</th>
<th>Citation Issued to</th>
<th>Weather conditions at time of accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐ NO ☐</td>
<td></td>
<td>OSU Driver ☐ Other Driver ☐ None ☐</td>
<td></td>
</tr>
<tr>
<td>Agency Name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## OSU DRIVER INFORMATION

<table>
<thead>
<tr>
<th>OSU Driver Name</th>
<th>Affiliation</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Faculty/Staff ☐ Student ☐ Volunteer ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Business Purpose

<table>
<thead>
<tr>
<th>Supervisor Name/Phone Number</th>
<th>Department/Org Code</th>
</tr>
</thead>
</table>

Injured?
YES ☐ NO ☐ If yes, Describe Injuries below. Notify your supervisor, they shall complete the [HR Advocate Public Incident Reporting Form](#). If seeking medical evaluation, take the enclosed “Employee Status Report” to medical professional to complete.

## OSU PASSENGER INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Injured? YES ☐ NO ☐

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## OSU VEHICLE INFORMATION

<table>
<thead>
<tr>
<th>E-Plate Number</th>
<th>Year</th>
<th>Make</th>
<th>Model</th>
<th>Damaged, if yes explain damage</th>
</tr>
</thead>
</table>

## OTHER DRIVER INFORMATION

<table>
<thead>
<tr>
<th>Other Driver Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
</table>

## OTHER PASSENGER INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Injured? YES ☐ NO ☐

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Injured? YES ☐ NO ☐

## OTHER VEHICLE INFORMATION

<table>
<thead>
<tr>
<th>License Plate Number</th>
<th>Year</th>
<th>Make</th>
<th>Model</th>
<th>Damaged, if yes explain damage</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>License Plate Number</th>
<th>Year</th>
<th>Make</th>
<th>Model</th>
<th>Damaged, if yes explain damage</th>
</tr>
</thead>
</table>

## WITNESS INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMPLETE BOTH SIDES OF FORM

ERS 06.17.15
Extent of Damage (check all that apply)

☐ Towed
☐ Rollover
☐ Towed
☐ Totaled
☐ Minor
☐ Other

Estimated Damage Total

$ __________________

NOTE: If over $2500 damage or ANY injury, complete the DMV Oregon Traffic Accident and Insurance Report and turn in to the DMV within 72 hours.

Use Arrow(s) to Point to Damage on Diagram

Additional Information

Please take and enclose photos of damage.
Employee Name: ________________________________ Date of Next Appointment: ____________________

NOTE: This form is used to assist the University in providing employees with reasonable accommodations and/or transitional work. PLEASE DO NOT INCLUDE MEDICAL DIAGNOSIS.

Current Status (check one only):
- [ ] Released to regular work without restrictions Date: ________________
- [ ] Released to modified work (indicate restrictions below) Date: ________________
- [ ] Not released to any form of work* Date: ________________
* Estimated date of release to work: ________________

Restrictions (fill in the blank, check box or circle restriction for each activity):

In a work day, limitations include: SIT _____ hours; STAND _____ hours; WALK _____ hours
At one time, limitations include: SIT _____ hours; STAND _____ hours; WALK _____ hours

BEND/STOOP
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

CLIMB
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

CRAWL
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

PUSH
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

PULL
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

REACH (above shoulder)
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

SQUAT
- Never
- Intermittently
- Occasionally
- Frequently
- Continuously

LIFT/CARRY/PUSH/PULL (weight restrictions)
- Up to 10 lbs.
- 11-20 lbs.
- 21-30 lbs.
- 31-40 lbs.
- 41-50 lbs.
- 51-100 lbs.

Use of Hands: Repetitive Action Simple Grasping Pushing/Pulling Fine Manipulation
Right N I O F C N I O F C N I O F C N I O F C
Left N I O F C N I O F C N I O F C N I O F C
N = Never 0% I = Intermittently 1-5% O = Occasionally 6-33% F = Frequently 34-66% C = Continuously 67-100%

Is the commute (as driver or passenger) to work within physical capacities of the employee? [ ] Yes [ ] No
Estimated time for transitional duty: ____________ Medically stationary? [ ] Yes (date) ____________ [ ] No

Please list any restrictions you believe will be permanent and affect the ability of the employee to perform work: ____________

Please list side effects from medication (prescribed for use during work hours) that may impair employee’s ability to safely perform work tasks: ____________

Comments: ________________________________________________________________________________

Print Physician’s Name: ________________________________ Telephone: ________________________________

Physician’s Signature: ________________________________ Date: ________________________________

Please return completed forms to Heidi Melton at email Heidi.Melton@oregonstate.edu
or to via fax at Fax 541-737-4855, or by mail to
Oregon State University, Insurance and Risk Management Services,
3015 SW Western Blvd (Oak Creek Building), Corvallis, OR 97333

Updated: 2/1/16
ONLY drivers involved in an accident resulting in any of the following MUST file an Accident & Insurance Report:
- Damage to your vehicle is over $2500
- Injury (No matter how minor)
- Death
- Damage to any one person's property over $2500
- Any vehicle has damage over $2500 and any vehicle is towed from the scene as a result of damages

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 and Insurance 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 those drivers required to report, unless the vehicle is parked.

If you have questions, please call the Crash Reporting Unit at (503) 945-5098.

INSTRUCTIONS

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 attached Supplemental Report (Form 735-32B), or on a blank piece of paper, write all the information as requested in Section 4, the "Other Driver" Section.
- DMV Headquarters will verify the insurance information submitted. Complete the insurance section or a suspension of your driving privileges may occur.

SECTION 1

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.

SECTION 2

YOUR VEHICLE (# 1) — DMV will consider your accident uninsured if you do not complete ALL of this section. You must list the insurance company name (not agent) and policy number 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.

SECTION 3

Answer all of the questions in Section 3. 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. Property includes, but is not limited to, fixed or real property, landscaping, signs, parked vehicles, and animals.

COMMERCIAL MOTOR VEHICLE OPERATORS: In addition to this report, Oregon Administrative Rule requires that Form 735-9229, Motor Carrier Crash 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 disabling damage. Form 735-9229 (attached on back) MUST be submitted with Oregon Traffic Accident and Insurance Report (Form 735-32) to DMV. Call (503) 986-3507 for questions regarding the Motor Carrier Crash Report.

SECTION 4

OTHER VEHICLE (# 2) — Completion of this information will help DMV match all driver's accident reports more efficiently. If additional vehicles were involved in the accident, complete attached Supplemental Report (Form 735-32B).

SECTION 5

DESCRIPTION AND SIGNATURE — Describe what happened. It is important for you to sign and date the form. Only a family member may sign and date this form on behalf of a driver when the driver is incapacitated or physically unable to sign. No other signatures will be accepted.

COMPLETING AND FILING REPORT

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 ORS 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.

MAIL — Mail the form to Crash Reporting Unit, DMV, 1905 Lana Ave NE, Salem OR 97314 or FAX to (503) 945-5267, or deliver it to any DMV office.

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 or 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 (banks or 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 Application for Salvage Title (Form 735-229) from any DMV office, by calling (503) 945-5000, or online at [www.oregondmv.com](http://www.oregondmv.com). Application instructions and fee information are on the back of the form 735-229. 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 $2500 in damage to your vehicle; 2) More than $2500 in damage to any one person’s property other than a vehicle; 3) Any vehicle has more than $2500 and any vehicle is towed from the scene as a result of damages; 4) Injury to any person (no matter how minor the injury); or, 5) the death of any person.

<table>
<thead>
<tr>
<th>ACCIDENT DATE</th>
<th>COUNTY</th>
<th>DO NOT WRITE IN THIS SPACE</th>
<th>Accident Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M T W TH F S S N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM PM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

- Two vehicles
- ATV / Snowmobile
- Parked vehicle
- More than two vehicles
- Motorcycle
- Overturned vehicle
- Fatality
- Motorized Scooter
- Animal
- Bicycle
- Personal (assisted)
- Mobility device
- Fixed object / property
- Pedestrian
- Train
- Other

COMPLETE ALL of this section. If you fail to do so, your driving privileges may be suspended. You MUST list the insurance company (not agent) and policy number that provided liability coverage for the vehicle you were driving.

SECTION 1: YOUR VEHICLE

DRIVER’S NAME (LAST, FIRST, MIDDLE)  DRIVER’S LICENSE NUMBER  STATE  DATE OF BIRTH  SEX (CIRCLE)

M F X

DRIVER’S RESIDENCE ADDRESS  CITY  STATE  ZIP CODE

MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)  CITY  STATE  ZIP CODE

VEHICLE OWNER’S NAME AND ADDRESS  CITY  STATE  ZIP CODE

SAME

INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS  CITY  STATE  ZIP CODE

POLICY NUMBER  VEHICLE IDENTIFICATION NUMBER  VEHICLE PLATE NUMBER  STATE  YEAR  MAKE & MODEL

Check all statements that apply:

☐ Damage to your vehicle was more than $2500.
☐ Damage to any one person’s property (other than vehicle) was more than $2500.
☐ Your vehicle was towed from the scene as a result of damages.
☐ You or passengers in your vehicle were injured.
☐ The accident occurred while you were driving your employer’s vehicle.
☐ You were driving on your job and being paid for the principal purpose of driving.
☐ You were being paid to drive and/or deliver persons or property.
☐ You were operating a government owned vehicle marked for transporting mail in accordance with government rules.
☐ You were operating an authorized emergency vehicle.
☐ You were transporting hazardous material.
☐ The accident occurred in a work or maintenance zone. ORS 811.230
☐ A police officer came to the scene.
☐ A citation was issued to you. The citation was:

SECTION 2: OTHER VEHICLE

DRIVER’S NAME (LAST, FIRST, MIDDLE)  DRIVER’S LICENSE NUMBER  STATE  DATE OF BIRTH  SEX (CIRCLE)

M F X

DRIVER’S ADDRESS  CITY  STATE  ZIP CODE

VEHICLE OWNER’S NAME AND ADDRESS  CITY  STATE  ZIP CODE

SAME

INSURANCE COMPANY NAME (NOT AGENT) AND ADDRESS

POLICY NUMBER  VEHICLE IDENTIFICATION NUMBER  VEHICLE PLATE NUMBER  STATE  YEAR  MAKE & MODEL

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

SECTION 3: DESCRIPTION OF ACCIDENT

DESCRIPT WHAT HAPPENED: (IF MORE SPACE IS NEEDED, SUBMIT ADDITIONAL PAGE)

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

SIGNATURE OF PERSON MAKING REPORT  PRINTED NAME OF PERSON MAKING REPORT  DAYTIME PHONE #  DATE SIGNED

☐ IF NOT DRIVER’S SIGNATURE, STATE RELATIONSHIP  REASON DRIVER IS UNABLE TO SIGN REPORT  PHONE NUMBER OF DRIVER ( )  ( )

735-32 (2-21)  COMPLETE THE OTHER SIDE OF THIS PAGE

DMV COPY
### 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, pickup, van
- Military vehicle
- Taxicab
- Emergency vehicle
- Any of the above and trailer
- Private or public agency transit vehicle
- Bus
- School bus
- Other publicly-owned veh.
- Motorcycle
- Motor–scooter/bike
- Personal (assisted) mobility device
- Truck tractor & semi trailer
- Truck/truck tractor
- Other truck combination
- Farm tractor/farm equip.

### 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:

### OTHER DRIVER WAS HEADED
- North
- East
- South
- West
- On:

### WITNESS INFORMATION:

### DRIVER AND PASSENGER INJURY AND SAFETY EQUIPMENT INFORMATION

#### SAFETY EQUIPMENT CODES
WRITE one of the codes (0–10) 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 Child restraint device not available
- 6 Helmet NOT in use
- 7 Helmet in use
- 8 Air bag deployed
- 9 Air bag available - NOT deployed
- 10 Air bag NOT available

#### INJURY CODE FOR OCCUPANTS
WRITE one of the codes (1–5) in column D
- 1 Fatal
- 2 Suspected Serious: severe laceration, broken or distorted limb, crush injury, significant burns, unconsciousness, paralysis
- 3 Suspected Minor: lump, abrasions, bruises, minor lacerations
- 4 Possible
- 5 No apparent

#### SEAT POSITION
- FRONT CENTER
- FRONT RIGHT
- MIDDLE LEFT
- MIDDLE CENTER
- MIDDLE RIGHT
- REAR LEFT
- REAR CENTER
- REAR RIGHT

#### PASSENGER'S NAMES (your vehicle)

---

### 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)

---

### SEX CODE
WRITE M, F or X in column A
- M
- F
- X

### Extent of pedestrian / bicyclist injury:
- Deceased
- Momentary unconsciousness / complaint of pain
- Incapacitated
- Visible injury
- No apparent 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

---

### Vehicle Damage
- FRONT

**USE ARROW TO SHOW**
- FIRST IMPACT (SHADE IN DAMAGED AREA)
  - Vehicle towed
  - Rollover
  - Under car
  - Totaled
  - Unknown

**Diagram**

- Number each vehicle:
- Show path by:
- Show pedestrian/bicyclist by:
- Show railroad tracks by:

Your Vehicle (No. 1) damage: $___________.

---

### Diagram

1. [Diagram of vehicle damage]
2. [Diagram of pedestrian/bicyclist path]

---

### Diagram

- [Diagram of railroad tracks]

---

### Diagram

- [Diagram of vehicle damage]
- [Diagram of pedestrian/bicyclist path]
- [Diagram of railroad tracks]
**SUPPLEMENTAL REPORT**

**OREGON TRAFFIC ACCIDENT**

Attach this form to your OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT.

**ACCIDENT DATE**

**DAY OF WEEK**

M | T | W | TH | F | S | SN
AM | PM

**TIME OF DAY**

**COUNTY**

**DO NOT WRITE IN THIS SPACE**

**ROAD ON WHICH ACCIDENT OCCURRED** (Name of street, road or route)

**MILE POST**

<table>
<thead>
<tr>
<th>VEHICLE #3</th>
<th>INSURANCE COMPANY NAME (NOT AGENCY)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLE IDENTIFICATION NUMBER</td>
<td>VEHICLE PLATE NUMBER</td>
<td>STATE</td>
</tr>
<tr>
<td>OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)</td>
<td>DRIVER'S LICENSE NUMBER</td>
<td>STATE</td>
</tr>
</tbody>
</table>

**DRIVER'S ADDRESS**

CITY | STATE | ZIP CODE

**VEHICLE OWNER'S NAME AND ADDRESS**

☐ SAME

<table>
<thead>
<tr>
<th>VEHICLE #4</th>
<th>INSURANCE COMPANY NAME (NOT AGENCY)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLE IDENTIFICATION NUMBER</td>
<td>VEHICLE PLATE NUMBER</td>
<td>STATE</td>
</tr>
<tr>
<td>OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)</td>
<td>DRIVER'S LICENSE NUMBER</td>
<td>STATE</td>
</tr>
</tbody>
</table>

**DRIVER'S ADDRESS**

CITY | STATE | ZIP CODE

**VEHICLE OWNER'S NAME AND ADDRESS**

☐ SAME

<table>
<thead>
<tr>
<th>VEHICLE #5</th>
<th>INSURANCE COMPANY NAME (NOT AGENCY)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLE IDENTIFICATION NUMBER</td>
<td>VEHICLE PLATE NUMBER</td>
<td>STATE</td>
</tr>
<tr>
<td>OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)</td>
<td>DRIVER'S LICENSE NUMBER</td>
<td>STATE</td>
</tr>
</tbody>
</table>

**DRIVER'S ADDRESS**

CITY | STATE | ZIP CODE

**VEHICLE OWNER'S NAME AND ADDRESS**

☐ SAME

<table>
<thead>
<tr>
<th>VEHICLE #6</th>
<th>INSURANCE COMPANY NAME (NOT AGENCY)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLE IDENTIFICATION NUMBER</td>
<td>VEHICLE PLATE NUMBER</td>
<td>STATE</td>
</tr>
<tr>
<td>OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)</td>
<td>DRIVER'S LICENSE NUMBER</td>
<td>STATE</td>
</tr>
</tbody>
</table>

**DRIVER'S ADDRESS**

CITY | STATE | ZIP CODE

**VEHICLE OWNER'S NAME AND ADDRESS**

☐ SAME

<table>
<thead>
<tr>
<th>VEHICLE #7</th>
<th>INSURANCE COMPANY NAME (NOT AGENCY)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLE IDENTIFICATION NUMBER</td>
<td>VEHICLE PLATE NUMBER</td>
<td>STATE</td>
</tr>
<tr>
<td>OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)</td>
<td>DRIVER'S LICENSE NUMBER</td>
<td>STATE</td>
</tr>
</tbody>
</table>

**DRIVER'S ADDRESS**

CITY | STATE | ZIP CODE

**VEHICLE OWNER'S NAME AND ADDRESS**

☐ SAME

735-328 (7-17)

SUPPLEMENTAL REPORT – USE IF MORE THAN TWO VEHICLES
INSTRUCTIONS: IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN AND A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE MOTOR CARRIER CRASH REPORT AND SUBMIT TO THE ADDRESS SHOWN ABOVE. IF YOU HAVE ANY QUESTIONS REGARDING FILLING OUT THE MOTOR CARRIER CRASH REPORT, PLEASE CALL (503) 966-3507.

QUALIFYING VEHICLE
☐ COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF CRASH EVEN IF GVWR IS SET UNDER 10,000 LBS)
☐ HAZARDOUS MATERIAL PLACARD
☐ COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS)
☐ FARM TRUCK INTERSTATE (OVER 10,000 LBS.)
☐ FARM TRUCK FOR-HIRE (4 OR MORE AXLES)
☐ FARM TRUCK TOWING TRIPLE TRAILERS
☐ FARM TRUCK (OVER 80,000 LBS.)

CRITERIA
☐ ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE ACCIDENT)
☐ ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE
☐ ANY VEHICLE INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE

MOTOR CARRIER NAME

US DOT NUMBER

AUTHORITY/FILE NUMBER

ADDRESS

CITY

STATE

ZIP CODE

DRIVER INFORMATION

DRIVER NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

LENGTH OF EMPLOYMENT
YEARS
MONTHS

CDL / DL NUMBER

STATE

LICENSE CLASS
☐ A ☐ B ☐ C ☐ D ☐ M

EXPIRATION DATE OF MEDICAL CERTIFICATE

COMPLETE THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF THE ACCIDENT.

AT TIME OF THE ACCIDENT, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD

TOTAL HOURS ON DUTY DURING THE PREVIOUS 7 CONSECUTIVE DAYS

(FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)

8 CONSECUTIVE DAYS

DOES YOUR DRIVER HAVE A MEDICAL WAIVER
☐ YES ☐ NO

TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)

DRIVER INJURY INFORMATION

YOUR DRIVER KILLED
☐ YES ☐ NO

YOUR DRIVER INJURED
☐ YES ☐ NO

RELIEF DRIVER KILLED
☐ YES ☐ NO

RELIEF DRIVER INJURED
☐ YES ☐ NO

TOTAL NUMBER OF PASSENGERS

KILLED INJURED

OTHER DRIVER INJURY INFORMATION

TOTAL NUMBER OF OTHER DRIVERS

KILLED INJURED

TOTAL NUMBER OF OTHER PASSENGERS

KILLED INJURED

TOTAL NUMBER OF PEDESTRIANS

KILLED INJURED

TOTAL NUMBER OF BICYCLISTS

KILLED INJURED

OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

MOTOR CARRIER NAME

VEHICLE LICENSE # AND STATE

DRIVER’S NAME

DRIVER’S LICENSE # AND STATE

MOTOR CARRIER VEHICLE INFORMATION

YEAR

MAKE

UNIT NUMBER

TRUCK/TRACTOR/BUS LICENSE PLATE NO. & STATE

TOTAL NO. OF AXLES INCLUDING TRAILERS

VEHICLE TYPE (SELECT APPROPRIATE TYPE)

1

3

Triplex (tractor with 3 trailers)

Standard Tractor/Semi Trailer

4

2

5

6

7

8

Saddlemount

Doubling (any)

Sedan

Standard

Tractor

Semi

Trailer

Auto/Pickup

Bus/Van (8 or more passenger capacity)

Henry Haul

11

10

9

8

7

6

5

4

3

2

1

735-9229 (2-21)

COMPLETE REVERSE SIDE

SUPPLEMENTAL – MOTOR CARRIER CRASH REPORT
CARGO BODY TYPE (CIRCLE ONE)
- VAN
- FLATBED
- TANKER
- CONTAINER
- POLE
- DUMP
- BELLY-DUMP
- CAR CARRIER
- LIVESTOCK
- MOBILE HOME
- TOTER
- PASSENGER
- DROP-BOX
- GARBAGE
- BULK-HOPPER
- MIXER
- SADDLEMOUNT
- WRECKER
- FIXED LOAD
- HEAVY HAUL
- UTILITY

TOTAL LENGTH OF VEHICLE/COMB | TOTAL WIDTH OF VEHICLE OR CARGO | CARGO WEIGHT | GROSS VEHICLE WEIGHT

COMMODITY INFORMATION

COMMODITY BEING TRANSPORTED AT TIME OF CRASH

- WAS A HAZARDOUS COMMODITY BEING HAULED
  - YES
  - NO

- WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO (NOT A FUEL RELEASE)
  - YES
  - NO

HAZARD CLASS

CRASH INFORMATION

LOCATION OF CRASH (NEAREST CITY OR TOWN)

HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD

DIRECTION OF YOUR VEHICLE (CIRCLE)
- N
- S
- E
- W

DATE OF CRASH

TIME
- AM
- PM

DAY OF THE WEEK (CIRCLE ONE)
- MON
- TUES
- WED
- THU
- FRI
- SAT
- SUN

CONDITIONS AT TIME OF ACCIDENT

WEATHER (CIRCLE ONE)
- 1. CLEAR
- 2. RAIN
- 3. SNOW
- 4. CLOUDY
- 5. SLEET
- 6. FOG
- 7. OTHER

ROAD SURFACE (CIRCLE ONE)
- 1. DRY
- 2. WET
- 3. SNOWY
- 4. ICY
- 5. OTHER

LIGHT CONDITION (CIRCLE ONE)
- 1. DAY
- 2. DAWN
- 3. DUSK
- 4. ARTIFICIAL LIGHTS
- 5. DARK
- 6. OTHER

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. YOUR VEHICLE IS ALWAYS NO. 1. IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 & 3 TO CORRESPOND TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

<table>
<thead>
<tr>
<th>VEHICLES 1 2 3</th>
<th>ACTION</th>
<th>VEHICLES 1 2 3</th>
<th>ACTION</th>
<th>VEHICLES 1 2 3</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLOWING - STOPPING</td>
<td>PASSING</td>
<td>CHANGING LANES</td>
<td>OVERTURN</td>
<td>SKIDDING</td>
<td>EXPLOSION</td>
</tr>
<tr>
<td>STOPPED</td>
<td>REAR-END</td>
<td>SIDESWIPE</td>
<td>SEPARATION OF UNITS</td>
<td>BACKING</td>
<td>HEAD-ON</td>
</tr>
<tr>
<td>MAKING RIGHT TURN</td>
<td>MAKING LEFT TURN</td>
<td>Vehicle out of control</td>
<td>CARGO SHIFT</td>
<td>MAKING U TURN</td>
<td>ROLL-AWAY</td>
</tr>
<tr>
<td>PROCEEDING STRAIGHT</td>
<td>CONTROLLED RR CROSSING</td>
<td>CARGO SPILL (NON-HAZARDOUS)</td>
<td>INTERSECTION</td>
<td>UNCONTROLLED RR CROSSING</td>
<td>OTHER (DEER, GUARDRAIL, ETC)</td>
</tr>
<tr>
<td>ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)</td>
<td>RAN OFF ROAD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DID YOUR VEHICLE STRIKE A PARKED VEHICLE
- YES
- NO

WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE
- YES
- NO

DESCRIPTION OF ACCIDENT BY CARRIER OFFICIAL

NAME AND TITLE OF PERSON SIGNING REPORT

TELEPHONE NUMBER(S)

SIGNATURE

I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE

DATE