VERMONT

REPORT OF A MOTOR VEHICLE CRASH

DEPARTMENT OF MOTOR VEHICLES
Agency of Transportation
120 State Street
Montpelier, Vermont 05603-0001
(voice) 802.828.2000
dmv.vermont.gov

A crash with more than 2 vehicles involved must fill out as many forms as needed to include all vehicles involved in the crash.

FOR OFFICE USE ONLY
DMV Crash Number

ALL INFORMATION REQUESTED MUST BE COMPLETED IN INK OR TYPEWRITTEN

THE OPERATOR OF EVERY MOTOR VEHICLE INVOLVED IN A CRASH WHICH RESULTS IN INJURY OR DEATH OR TOTAL PROPERTY DAMAGE OF $3,000.00 OR MORE (THIS INCLUDES ALL VEHICLES INVOLVED AND PHYSICAL PROPERTY DAMAGE), MUST MAKE A REPORT ON THIS FORM WITHIN 72 HOURS TO THE ABOVE ADDRESS. YOU MUST REPORT EVEN IF VEHICLE WAS PARKED. THE FAILURE OR REFUSAL OF ANY PERSON TO REPORT MAY BE PUNISHABLE BY A CIVIL PENALTY. INSURANCE INFORMATION IS REQUIRED

TIME OF CRASH	DAY OF WEEK	MONTH DAY YEAR OF CRASH	PLACE OF CRASH (CITY OR TOWN)	STREET/ROUTE/HIGHWAY OF CRASH
❑ A.M. ❑ P.M.		/ /		

IF YOUR (OPERATOR #1) ADDRESS IS DIFFERENT FROM THE ADDRESS ON DMV RECORDS AND THIS FORM IS SIGNED BY YOU THIS FORM WILL BE CONSIDERED TO BE A NOTICE OF ADDRESS CHANGE AND YOUR ADDRESS WILL BE CHANGED ON DMV RECORDS.

YOUR VEHICLE	NUMBER OF OCCUPANTS	**OTHER VEHICLE OR PEDESTRIAN OR BICYCLIST**	NUMBER OF OCCUPANTS
OPERATOR NAME: LAST / FIRST / MIDDLE		**OPERATOR NAME:** LAST / FIRST / MIDDLE	
STREET OR BOX NO.		STREET OR BOX NO.	
CITY OR TOWN / STATE		CITY OR TOWN / STATE	
ZIP CODE / DATE OF BIRTH / GENDER		ZIP CODE / DATE OF BIRTH (IF KNOWN) / GENDER (IF KNOWN)	
OPERATOR'S LICENSE NO. / CLASS / STATE		OPERATOR'S LICENSE NO. (IF KNOWN) / CLASS (IF KNOWN) / STATE	
IDENTIFICATION NUMBER / PLATE NUMBER / PLATE STATE		IDENTIFICATION NUMBER / PLATE NUMBER / PLATE STATE	
VEHICLE YEAR / VEHICLE MAKE / VEHICLE MODEL / VEHICLE TYPE		VEHICLE YEAR / VEHICLE MAKE / VEHICLE MODEL / VEHICLE TYPE	
TRAILER YEAR / TRAILER MAKE / TRAILER MODEL / TRAILER PLATE #		TRAILER YEAR / TRAILER MAKE / TRAILER MODEL / TRAILER PLATE #	
COMMERCIAL VEHICLE ☐ YES ☐ NO / HAZARDOUS MATERIAL ☐ YES ☐ NO		COMMERCIAL VEHICLE ☐ YES ☐ NO / HAZARDOUS MATERIAL ☐ YES ☐ NO	
ACTUAL COST OF VEHICLE #1 REPAIRS			ACTUAL COST OF VEHICLE #2 REPAIRS
PROPERTY DAMAGE OTHER THAN VEHICLE			PROPERTY DAMAGE OTHER THAN VEHICLE
APPROXIMATE COST OF PROPERTY **REPAIRS**			APPROXIMATE COST OF PROPERTY REPAIRS
PROPERTY OWNER'S NAME **AND ADDRESS:**			PROPERTY OWNER'S NAME **AND ADDRESS:**

IF THE CRASH INVOLVED A PEDESTRIAN OR A BICYCLIST, COMPLETE THE FOLLOWING INFORMATION

WHAT WAS PEDESTRIAN OR BICYCLIST DOING

☐ WALKING WITH TRAFFIC	☐ PLAYING IN ROAD	☐ UNKNOWN
☐ WALKING AGAINST TRAFFIC	☐ GETTING ON/OFF VEHICLE	
☐ NOT IN ROADWAY	☐ PUSHING VEHICLE	
☐ CROSSING INTERSECTION	☐ WORKING ON VEHICLE	
☐ CROSSING NOT AT AN INTERSECTION	☐ RIDING/PUSHING BIKE	

OTHER:

DESCRIBE INJURY:

OCCUPANT DATA

THE INFORMATION BELOW IS REQUIRED FOR YOURSELF AND ALL OCCUPANTS IN ALL VEHICLES (ATTACH ADDITIONAL SHEETS IF THERE IS NOT ENOUGH ROOM BELOW)

OCCUPANT'S NAME AND ADDRESS (USE THE FIRST LINE FOR YOURSELF EVEN IF NOT INJURED)	NATURE AND EXTENT OF INJURY (STATE "NONE" IF NOT INJURED)	NAME OF HOSPITAL INJURED TAKEN TO	THIS INFORMATION IS REQUIRED					
			VEH NO	POSITION WITHIN VEHICLE	AGE OF OCC.	GENDER	WAS SEATBELT OR HARNESS USED	WAS OCCUPANT THROWN FROM VEHICLE
			1	YOURSELF DRIVER				

CONTINUE ON NEXT PAGE

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED (ATTACH SHEET IF NECESSARY)

WAS THIS CRASH INVESTIGATED BY AN OFFICER?	☐	Yes	☐	No	IF YES, GIVE NAME OF OFFICER:	
OFFICER'S DEPARTMENT:						

WERE YOU DRIVING A COMMERCIAL VEHICLE?	☐	Yes	☐	No
WAS THE VEHICLE TRANSPORTING HAZARDOUS MATERIALS?	☐	Yes	☐	No
IF YES, GIVE NAME OF MATERIAL				

OPERATOR SIGN HERE	**Date of Report**

CONTINUE ON NEXT PAGE

IMPORTANT: You must furnish the insurance information requested for the vehicle you were operating.

Vermont law requires that any person involved in a crash which has resulted in bodily injury or death to any person or whereby the motor vehicle then under his control or any other property is damaged in an aggregate amount to the extent of $3,000 or more must furnish the commissioner with satisfactory proof that a standard provisions automobile liability insurance policy was in full force and effect at the time of the crash.

Any person who fails to furnish satisfactory proof that liability insurance was in force at the time of the crash may be required to obtain and furnish proof that Financial Responsibility Insurance has been obtained covering such person in the future operation of any motor vehicle.

(OPERATOR #1) MUST COMPLETE BOTH SECTIONS BELOW IN FULL. IF YOU FAIL TO GIVE FULL INFORMATION BELOW, IT WILL BE ASSUMED THAT YOU DO NOT HAVE AUTOMOBILE LIABILITY INSURANCE AND A SUSPENSION OF YOUR LICENSE/PRIVILEGE TO OPERATE IN VERMONT WILL BE ISSUED.

DMV CRASH NUMBER

Was an Automobile Liability Insurance policy, providing you AT LEAST $25,000/$50,000 bodily injury and $10,000 property damage insurance in effect on the date of the above crash? You **must** answer Yes or No. ❑Yes ❑ No

Name of your (Operator 1) Insurance Company (NOT AGENT): _____

Insurance Company Mailing Address: _____

Policy Number: _____ Policy Period From: _____ to _____

Name of Policy Holder: _____ Address _____

Name of Operator at the time of the Crash: _____ Date of Crash: _____

Is this motor vehicle covered by a Certificate of Self-Insurance? ☐ Yes ☐ No If yes, certificate number: _____

DO NOT DETACH FORM SR-21A

VERMONT DEPARTMENT OF MOTOR VEHICLES

DMV CRASH NUMBER

Name of insurance company with whom you are insured for liability or damage to others **(For Operator #1)**: _____

Insurance Company mailing address: _____

Policy Number: _____ Policy Period From: _____ to _____

Date of Crash: _____ At or near (Town/City): _____

Make of your vehicle: _____ Year: _____ Type: _____ VIN: _____

Operator: _____ Address: _____

Name of Policy Holder: _____ Signature of Operator: _____

IMPORTANT! ! THIS CRASH SHOULD ALSO BE REPORTED DIRECTLY TO YOUR INSURANCE COMPANY. FAILURE TO REPORT MAY JEOPARDIZE YOUR AUTOMOBILE LIABILITY

DO NOT WRITE IN THE SECTION BELOW – IT IS FOR USE OF INSURANCE COMPANY ONLY

TO INSURANCE COMPANY

Return this form within 15 days if no policy, or insufficient policy was in effect as alleged by motorist. **If notification is not received within 15 days, it will be assumed the required insurance was in effect at the time of the crash.** Send to :

COMMISSIONER OF MOTOR VEHICLES, 120 STATE STREET, MONTPELIER, VERMONT 05603-0001

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

❑ 1. No such policy was in effect at the time of the crash.

❑ 2. Our policy affords limits of liability less than $25,000/$50,000 bodily injury and $10,000 property damage (indicate actual limits under remarks).

REMARKS :

NAME OF INSURANCE COMPANY: AUTHORIZED REPRESENTATIVE:

DATE :