Quality Driver Solutions, Inc.
"Your Translogistics Staffing Source"

Quality Driver Solutions, Inc.

Accident Forms

This vehicle accident report must be completed and signed upon being involved in any vehicular accident. It must be mailed or faxed to Quality Driver Solutions, Inc. within 24 hours of the incident.

If you become involved in an accident follow these steps:

Stop immediately.

1. Set out warnings (fuses, reflectors, 4 way flashers, etc…) to avoid further accidents.
2. Immediately tend to anyone injured, and then call for medical help.
3. Notify Police.
4. Telephone Quality Driver Solutions, Inc. dispatch immediately from the nearest telephone or have someone call. Do not continue your duties until you are instructed by a Quality Driver Solutions, Inc. dispatcher to do so.
5. Do not move equipment if its position is helpful to you, unless it is creating a hazard. If you must move your vehicle, mark its positions before moving it.
6. Do not admit liability.
7. Do not sign anything except the police report, if one is taken.
8. Do not argue the facts of the incident. Give facts to the police, unless a death is involved. If a death is involved do not talk or give any statements. You have this right by law.
9. Protect your equipment from further damage or theft.

Call your QDS 24 hour Dispatch Immediately!!

ACCIDENT REPORT FORM

Date of Report: _____ Time of Report: _____:_____ am / pm

Supervisor Notified?: ☐ Yes ☐ No Client Notified?: ☐ Yes ☐ No

Name of Supervisor: _____ Name of Client: _____

Name of Person Notified: _____

Time of Notification: _____:_____ am / pm Time of Notification: _____:_____ am / pm

DRIVER INFORMATION

Driver Name: _____ Phone Number: _____

CDL Number: _____ Expiration Date: _____ CDL State: _____

Injured?: ☐ Yes ☐ No Injury Type: _____

Treated at Scene?: ☐ Yes ☐ No

WITNESS(ES)

WITNESS #1

Name:_____
Address: _____
City, State, Zip: _____
Phone: ( ) _____-_____

WITNESS #2

Name:_____
Address: _____
City, State, Zip: _____
Phone: ( ) _____-_____

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____:_____ am / pm

Location of Accident (include City & State): _____

Name of Street or Highway: _____ Intersection: _____

Distance and Direction from nearest community junction, etc.: _____

☐ Open Country ☐ Residential ☐ Business-Shopping ☐ Manufacturing-Industrial

☐ Other (Describe): _____

Weather Condition: ☐ Clear/Sun ☐ Cloudy ☐ Fog ☐ Wind ☐ Rain ☐ Sleet ☐ Snow

Road Condition: ☐ Dry ☐ Wet ☐ Icy ☐ Under Construction ☐ Other (Specify): _____
Light Condition: ☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark-Road Lighted ☐ Dark-Road Unlighted
Was Ambulance called?: ☐ Yes ☐ No Was ANYONE injured?: ☐ Yes ☐ No
Was Company Vehicle Towed?: ☐ Yes ☐ No Towing Agency: _____
Location where vehicle was towed: _____

LAW ENFORCEMENT INFORMATION

Law Enforcement Investigation: ☐ Yes ☐ No Enforcement Agency: _____
Office Name: _____ Badge No.: _____ Report No.: _____
Citations issued: ☐ Yes ☐ No Citation(s) issued to: _____
Reason: _____
_____
_____

VEHICLE #1 (COMPANY VEHICLE)

TRACTOR

Vin No: _____
Fleet No: _____
Year: _____
Make/Model: _____
Tag No.&State: _____

CARGO

Commodities Being Hauled: _____
_____
Shipper: _____
Product Damage: ☐ Yes ☐ No
Summary of Damage: _____

OTHER VEHICLE(S) INVOLVED

Vehicle #2

Make/Model: _____
Color: _____
License Plate: _____ State: _____
Insurance Co: _____
Policy No: _____
Was the Vehicle Towed: ☐ Yes ☐ No

Driver Name: _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____-_____
Company (?): _____
Driver License: _____ State: _____
If Driver is not owner of vehicle:
Driver Name: _____
Address: _____
City, State, Zip: _____

Vehicle #3

Make/Model: _____
Color: _____
License Plate: _____ State: _____
Insurance Co: _____
Policy No: _____
Was the Vehicle Towed: ☐ Yes ☐ No

Driver Name: _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____-_____
Company (?): _____
Driver License: _____ State: _____
If Driver is not owner of vehicle:
Driver Name: _____
Address: _____
City, State, Zip: _____

Telephone: ( ) _____-_____
Passenger Name: _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____-_____

Was there an injury?: ☐ Yes ☐ No
To: ☐ Driver ☐ Passenger
☐ Other: _____
Type of injury: _____
Was treated at scene? ☐ Yes ☐ No
Was taken by Ambulance?: ☐ Yes ☐ No
Where taken?: _____
Address: _____
Was there a fatality?: ☐ Yes ☐ No
To: ☐ Driver ☐ Passenger
☐ Other: _____

Telephone: ( ) _____-_____
Passenger Name: _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____-_____

Was there an injury?: ☐ Yes ☐ No
To: ☐ Driver ☐ Passenger
☐ Other: _____
Type of injury: _____
Was treated at scene? ☐ Yes ☐ No
Was taken by Ambulance?: ☐ Yes ☐ No
Where taken?: _____
Address: _____
Was there a fatality?: ☐ Yes ☐ No
To: ☐ Driver ☐ Passenger
☐ Other: _____

TYPE OF ACCIDENT (check all that apply)

☐ Collision with other vehicle ☐ Collision with fixed object

	Vehicle 1	Vehicle 2	Vehicle 3
☐ Ran off road	☐	☐	☐
☐ Overturn in road	☐	☐	☐
☐ Mechanical Defect	☐	☐	☐
☐ Fire	☐	☐	☐
☐ Loading/Unloading	☐	☐	☐
☐ Boarding/Alighting	☐	☐	☐
☐ Occupant fell out	☐	☐	☐
☐ Occupant injured	☐	☐	☐
☐ Other: _____	☐	☐	☐

PEDESTRIAN INVOLVEMENT (check all that apply)

☐ Non
☐ Crossing at Intersection
☐ Between Intersections
☐ With Signal
☐ Against Signal
☐ No Signal
☐ Other (describe): _____

☐ Diagonally
☐ Walking on Roadway
☐ Sidewalk
☐ No Sidewalk
☐ With Traffic
☐ Against Traffic

VEHICLE 1 MOVEMENT (check all that apply)

- ☐ Straight Ahead
- ☐ Turning Right
- ☐ Turning Left
- ☐ Slowing or Stopping
- ☐ Stopped in Traffic
- ☐ Started in Traffic
- ☐ Starting from Curb/Shoulder
- ☐ Evasive Action
- ☐ Other (describe) : _____
- ☐ Parked
- ☐ Backing
- ☐ U-turn
- ☐ Skidding
- ☐ Overtaking
- ☐ Weaving
- ☐ Wrong Side
- ☐ Crowded off Road

VEHICLE 1 MECHANICAL CONDITION (check all that apply)

	Vehicle 1	Vehicle 2	Vehicle 3
☐ No Defect	☐	☐	☐
☐ Lights	☐	☐	☐
☐ Brakes	☐	☐	☐
☐ Tires/Wheels	☐	☐	☐
☐ Engine	☐	☐	☐
☐ Couplings	☐	☐	☐
☐ Windshield/Window	☐	☐	☐
☐ Disabled	☐	☐	☐
☐ Other: _____	☐	☐	☐

ROADWAY CONDITIONS AND CONTROLS (check all that apply)

- ☐ Not at Intersection
- ☐ Street Intersection
- ☐ Drive of Alley
- ☐ Crosswalk
- ☐ Other (describe): _____
- ☐ Bridge/Overpass
- ☐ Under Pass
- ☐ Private Property
- ☐ Other off-street

☐ Not divided ☐ Divided ☐ Limited Access

Number of Lanes: 2 3 4 5 6

ROAD SURFACE (check all that apply)

- ☐ Lanes Marked
- ☐ Concrete
- ☐ Blacktop
- ☐ Metal Grating/Bridge
- ☐ Other (specify): _____
- ☐ Lanes Unmarked
- ☐ Gravel
- ☐ Other/Unpaved

☐ No Defects
☐ Dry
☐ Wet
☐ Ice
☐ Snow

☐ Mud
☐ Loose Material
☐ Cracks, Holes, etc.
☐ Fresh Oil
☐ Under Construction or Repair

☐ Straight
☐ Curve R L

☐ Level
☐ Sharp

☐ Hills
☐ Moderate

TRAFFIC CONTROLS (check all that apply)

☐ Traffic Light
☐ Stop Sign
☐ Yield Sign
☐ Police Office

☐ RR Crossing Signal/Gate
☐ No Traffic Control
☐ Posted Speed Limit
☐ Other Controls

Were traffic controls operating? ☐ Yes ☐ No

PROPERTY DAMAGE (check all that apply)

POINT OF IMPACT

	Vehicle 1	Vehicle 2	Vehicle 3
Front	☐	☐	☐
Rear	☐	☐	☐
Right Front	☐	☐	☐
Left Front	☐	☐	☐
Right Rear	☐	☐	☐
Left Rear	☐	☐	☐
Right Side	☐	☐	☐
Left Side	☐	☐	☐
Roof	☐	☐	☐

Other: _____

Cargo Weight/Type: _____

Other Property Damage: _____

MISCELLANEOUS INFORMATION

Time you reported for duty: _____ : _____ am/pm

Total preceding hours off duty:_____

Hours since last sleep at time of going on duty: _____

Hours on duty at time of accident: _____

Time since last meal/rest break before accident: _____ Miles traveled this trip until accident: _____

Work reporting location: _____

Destination this trip: _____

WHAT HAPPENED?

At what distance did you first see danger? _____ FT
How fast were you going? _____ MPH
What was your speed impact? _____ MPH
How far did your vehicle travel after impact? _____ FT

Describe in your own words the circumstances of the accident: _____

Driver Name: _____

Driver Signature: _____

Date Signed: _____

Quality Driver Solutions, Inc.
"Your Translogistics Staffing Source"

ACCIDENT INVESTIGATION

(To be completed by Supervisor or Manager with Driver)

Investigated By: _____ Title: _____

Driver Name: _____

Total Driving Experience: _____ Years

Number of Accidents in Last 3 Years: _____

Number of Violations in Last 3 Years: _____

Total Hours Worked in Previous 7 Days: _____

On Duty Hours at Time of Accident: _____ Hours _____ Minutes

Violation of On Duty Hours: ☐ Yes ☐ No

1. Was This Accident Preventable?: ☐ Yes ☐ No

2. Contributing Factors:_____

_____

_____

_____

_____

_____

_____

3. Direct Cause of Accident: _____

_____

_____

_____

_____

_____

_____

4. Steps Taken to Prevent Future Accidents: _____

_____

_____

_____

_____

_____

_____

Investigator's Signature: _____

Investigator's Title: _____

Quality Driver Solutions, Inc.
"Your Translogistics Staffing Source"

Accident Diagram
(Please draw a diagram of accident)