
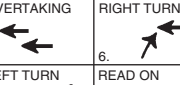
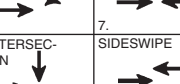
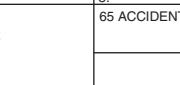
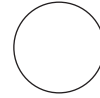



NEW JERSEY MOTOR VEHICLE COMMISSION
MOTOR VEHICLE ACCIDENT REPORT

Follow Instructions
on other side

14 ACCIDENT DATE MO. DAY YEAR		15 DAY OF WK.		16 TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		17 NUMBER OF VEHICLES		18 NUMBER KILLED		19 NUMBER INJURED		20 DID POLICE INVESTIGATE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		21 NAME OF POLICE AGENCY									
22 LOCATION OF ACCIDENT (MUNICIPALITY)						23 ROUTE NUMBER OR NAME OF STREET						24 IF NOT AT INTERSECTION COLLISION WAS BETWEEN: ROAD 1 _____ ROAD 2 _____ DISTANCE FROM ROAD 1 _____											
25 COUNTY						26 INTERSECTING STREET, ROAD OR RAILROAD																	
27 INSURANCE COMPANY						44 INSURANCE COMPANY																	
Your Vehicle No. 1 28 POLICY NO.						Other Vehicle No. 2 45 POLICY NO.																	
29 DRIVER'S FIRST NAME INITIAL LAST NAME						46 DRIVER'S FIRST NAME INITIAL LAST NAME																	
30 NUMBER AND STREET						47 NUMBER AND STREET						1											
31 CITY STATE ZIP CODE						48 CITY STATE ZIP CODE																	
32 DRIVERS LICENSE NUMBER				33 STATE		34 BIRTHDATE MO. DAY YEAR		35 EYE COLOR		36 SEX		49 DRIVERS LICENSE NUMBER											
												50 STATE 31 BIRTHDATE 52 EYE COLOR 53 SEX											
37 OWNER'S FIRST NAME INITIAL LAST NAME <input type="checkbox"/> SAME AS DRIVER						54 OWNER'S FIRST NAME INITIAL LAST NAME <input type="checkbox"/> SAME AS DRIVER																	
38 NUMBER AND STREET						55 NUMBER AND STREET						3											
39 CITY STATE ZIP CODE						56 CITY STATE ZIP CODE						4											
40 MAKE OF VEHICLE			41 YEAR		42 LICENSE PLATE NO.			43 STATE		57 MAKE OF VEHICLE			58 YEAR		59 LICENSE PLATE NO.		60 STATE						
61 DESCRIBE DAMAGE TO VEH. NO. 1		62 CIRCLE ONE OF THE 8 DIAGRAMS BELOW IF IT ADEQUATELY DESCRIBES THE ACCIDENT OR DRAW YOUR OWN DIAGRAM IN THE SPACE TO THE RIGHT    				63 9				DIAGRAM  INDICATE NORTH				64 DESCRIBE DAMAGE TO VEH. NO. 2									
EST. COST TO REPAIR										EST. COST TO REPAIR													
INJURED LOCATED 1 IN VEH. 1 B ON A PEDALCYCLE O OTHER 2 IN VEH. 2 P PEDESTRIAN		65 ACCIDENT DESCRIPTION																					
POSITION IN/ON VEHICLE 1 DRIVER 2 THRU 7 PASSENGERS 8 RIDING/HANGING ON OUTSIDE 		VICTIM'S PHYSICAL CONDITION 1 KILLED 2 INCAPACITATED 3 MODERATE INJURY 4 COMPLAINT OF PAIN				66 DESCRIBE DAMAGE TO PROPERTY OTHER THAN VEHICLE (GIVE OWNER'S NAME AND ADDRESS AND EST. COST TO REPAIR)																	
67		68		69		70 AGE		71 SEX		Injury Section: Fill Out Space Below for Every Person Injured or Killed in the Accident.													
										NAME AND ADDRESS OF INJURED													
										NATURE OF INJURY													
										NAME AND ADDRESS OF INJURED													
										NATURE OF INJURY													
SIGN HERE						Date of Report																	
FILL IN BUT DO NOT DETACH																							
NEW JERSEY SR-21						If you fail to give full information below, it will be assumed that you did not have automobile liability insurance.						Fill in this form with information from your insurance policy. All information will be verified with the insurance company.											
NAME OF INSURANCE COMPANY COVERING YOU FOR LIABILITY FOR DAMAGE OR INJURY TO OTHERS (NOT AGENT)																							
NAME AND ADDRESS OF INSURANCE AGENT WHO SOLD YOU POLICY																							
POLICY NO.									POLICY PERIOD FROM TO														
DATE OF ACCIDENT MONTH DAY YEAR						MAKE OF YOUR VEHICLE (NO. 1) YEAR						VEHICLE IDENTIFICATION NO.											
LOCATION OF ACCIDENT - STREET OR ROUTE NO. AND MUNICIPALITY (SAME AS ITEMS 22, 23, 24, ABOVE)																							
NAME AND ADDRESS OF DRIVER - VEHICLE 1																							
NAME AND ADDRESS OF OWNER - VEHICLE 1																							
NAME AND ADDRESS OF POLICY HOLDER - VEHICLE 1																							
IMPORTANT - This accident should also be reported directly to your Insurance representative. Failure to report may jeopardize your vehicle liability insurance.																							

FOLLOW INSTRUCTIONS ON OTHER SIDE

SECTION A

Report of Accidents. The driver of a vehicle involved in an accident resulting in injury to or death of any person, or damage to property of any one person in excess of five hundred dollars (\$500) shall within ten days after such accident forward a written report of such accident TO: NJ DEPARTMENT OF TRANSPORTATION, 1035 PARKWAY AVENUE, CN 600, TRENTON, NJ 08625-0600 ATTN: BUREAU OF TRANSPORTATION DATA AND SAFETY. Failure to report will result in the suspension of both driving and registration privileges. Under Chapter 4 of Title 39 these reports are not available for public information nor are they admissible in evidence for any other purpose in a proceeding or action arising out of the accident. They are solely for the use of the Department of Transportation in developing information useful in the prevention of accidents and for compliance with the Motor Vehicle Security Responsibility and Compulsory Insurance Laws. "A written report of an accident shall not be required if a law enforcement officer submits a written report of the accident to the division pursuant to R.S. 39:4-131."

**INSTRUCTIONS
PLEASE PRINT OR TYPE
ALL INFORMATION
USE BLACK OR DARK BLUE INK**

Begin by folding along this line →
Follow the instructions at the top of Section B.
Numbered arrows should point to boxes on reverse side after folding.

1. Give exact date of accident.
2. If a vehicle is unoccupied, enter all available information. Be sure to enter the correct vehicle plate number.
3. Driver information must be entered exactly as it appears on each driver's license.
4. Owner information must be entered exactly as it appears on the registration certificate of each vehicle involved in the accident.
5. If you were involved in an accident in which there were more than two vehicles, an additional one of these report forms must be filled out. On that form, place the information for the third vehicle in the space marked "Your Vehicle No. 1" and mark it No. 3. Use the space marked "Other Vehicle No. 2" for the fourth vehicle, and mark it No. 4 and so on.
6. The location of the accident is very important and you should describe it as accurately as possible in the space provided.
7. For each person injured complete boxes 67, 68, 69, 70, 71 and list names and addresses.
8. If there are more than two persons injured, another one of these report forms is needed. In the injury section of that report, record the required information for all additional injured persons.
9. Attach any additional report forms to page one. Each page of the report must be numbered in the upper right corner, dated and SIGNED on the bottom line.
10. Answer all questions to the best of your knowledge.
11. Send all reports to:

**NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
PO BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF TRANSPORTATION
DATA AND SAFETY**

SECTION B

REPORT OF MOTOR VEHICLE ACCIDENT

Be sure form is folded along this line before answering the questions below.

Numbered arrows should point to boxes on reverse side after folding.

Fill in the 13 boxes to the right by entering the number of the item which best describes the circumstances of the accident.

If a question does not apply enter a dash (—).
If an answer is unknown enter a "U".

SURFACE CONDITION		1
1 DRY 2 WET	3 SNOWY 4 ICY	5 OTHER
LIGHT CONDITION		2
1 DAYLIGHT 2 DAWN OR DUSK	3 DARK (ST LIGHT ON) 4 DARK (ST LIGHT OFF) 5 DARK (NO ST LIGHTS)	
WEATHER		3
1 CLEAR 2 RAIN 3 SNOW	4 FOG 5 OTHER	
DIRECTION OF TRAVEL		4
		YOUR VEHICLE NO. 1
		VEHICLE NO. 2
VEHICLE TYPE		6
1 PASS CAR — STATION WAGON 2 PASS CAR W/TRAILER 3 TRUCK 4 TRUCK COMBINATION 5 RECREATION VEHICLE 6 TAXICAB/LIMOUSINE	7 BUS 8 SCHOOL BUS 9 EMERGENCY VEHICLE 10 MOTORCYCLE 11 OTHER	YOUR VEHICLE NO. 1 OTHER VEHICLE NO. 2
COLLISION INVOLVED		8
1 PEDESTRIAN 2 OTHER MOTOR VEHICLE 3 OVERTURNED 4 OTHER NON-COLLISION	5 PEDALCYCLE 6 ANIMAL 7 FIXED OBJECT 8 OTHER OBJECT	
LOCATION OF FIRST EVENT		9
1 ON ROADWAY	2 OFF ROADWAY	
VEHICLE POSITION		10
WAS VEHICLE LEGALLY PARKED AT CURB? 1 YES 2 NO		YOUR VEHICLE NO. 1 OTHER VEHICLE NO. 2
DRIVER EMPLOYMENT		12
WAS DRIVER EMPLOYED BY THE VEHICLE OWNER? 1 YES 2 NO		YOUR VEHICLE NO. 1 OTHER VEHICLE NO. 2

FOLD ALONG THIS LINE

Please Read Instructions 1 Through 11 On other Side of Fold Before Completing The inside of Report.

DO NOT FILL IN

**FOR USE OF INSURANCE COMPANY ONLY
Instructions for Insurance Company**

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

- 1. No policy was in effect on the date of the accident.
- 2. Our policy for the named policyholder applies to him as the operator but it does not apply to the owner of the vehicle involved in the accident.
- 3. Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident.
- 4. Other; explain.

**NJ DEPARTMENT OF TRANSPORTATION
1035 PARKWAY AVENUE
PO BOX 600
TRENTON, NJ 08625-0600
ATTN: BUREAU OF TRANSPORTATION
DATA AND SAFETY**

Name of Insurance Company

MUST be signed by Authorized Representatives