

MOTOR VEHICLE SAFETY OFFICE
DEPARTMENT OF TRANSPORTATION OF THE STATE OF HAWAII
MOTOR VEHICLE ACCIDENT REPORT

NOTE:
1. Injury or Death
2. \$4,400 and over

1. Name of carrier _____ (Corporate business name)

2. Principal business address _____ (Street and number) _____ (City or town) _____ (State)

3. Type of carrier _____

4. Date accident occurred _____ (Month) _____ (Day of Month) _____ (Year) 5. Day of week _____ 6. Hour _____ A. M. Noon P. M. Midnight

7. Place where accident occurred: State _____ County _____ City _____

8. On _____ At ; Near _____ (Street or highway route or name) _____ (Intersecting street or highway, house number, bridges, railroad crossing, or other landmark)

9. The run on which this accident occurred began at: _____ (City or town) _____ on _____ (Month — day) _____ at _____ A. M. P. M.

10. Type of Vehicle	Year Model	Make	DOT Insp. Sticker No.	Date of Insp.	License No.	Model or Serial No.	Type of Body	Company No.	Weight Empty	Weight of Payload
Truck (single unit)										
Tractor										
Semitrailer										
Full trailer										
Pole trailer										
Bus										
School Bus										
Taxi										
Limousine										

11. Over-all length of vehicle or combination _____ ft. 12. Kind of cargo at time of accident _____

13. Number of persons on vehicle (including driver) _____

14. (a) Is the power unit owned by you (the carrier)? Yes No 14. (b) If not owned by you, is it owned by the driver? Yes No 14. (c) Is vehicle registered with DOT? Yes No

15. Name and address _____ (Full name) _____ (Street and number or RFD) _____ (City) _____ (State)

16. Age _____ 17. Sex _____ 18. Social Security No. _____ 19. Length of time employed by you _____ (Years and months)

16. (a) Date of Doctor's Certificate _____

20. Experience driving any type motor vehicle _____ (Years and months) 21. Experience driving any type commercial vehicle _____ (Years and months) 22. Experience driving type vehicle in this accident _____ (Years and months)

23. Hours on duty since last period of 8 consecutive hours off duty _____ 24. Hours actually driving since last period of 8 consecutive hours off duty _____

25. Condition of driver: Sick Dozed at wheel Physical defect or other condition Had been drinking Apparently normal (Specify defect or condition)

TYPE OF ACCIDENT.

26. Noncollision—overturnd in roadway Noncollision—ran off roadway Collision with _____ (Pedestrian, private car, truck, fixed object, etc.) Other _____ (Specify)

27. Did this accident involve fire or explosion? Yes No

OTHER VEHICLES INVOLVED. (Use another sheet for additional vehicles involved)

28. _____ (Name of owner of vehicle No. 2) _____ (Address—city and State) Type of vehicle _____ License No. _____

29. _____ (Name of owner of vehicle No. 3) _____ (Address—city and State) Type of vehicle _____ License No. _____

WITNESSES.

30. _____ (Name) _____ (Address) _____ (Age—approximate)

31. _____ (Name) _____ (Address) _____ (Age—approximate)

(OVER)