GILLS point S TIRE & AUTO SERVICE

Company Motor Vehicle Report

Employee Data: _____

Employee Name:_____ Store Location/Number:_____

Employee Phone #: _____

Accident Details

Accident Location: Street _____ City _____ State _____County

Accident Date _____ Accident Time _____ ◉ AM ○ PM

Date Reported to Manager __ _____ Safety Belt On? ☐ Yes ☐ No ☐ Unknown

Employee Injured? ☐ Yes ☐ No If yes, fill out Employee accident injury report.

Accident Description (What Happened)

Witness Information _____

Witness Name: _____ Address street: _____

City: _____ State: _____ Zip: _____

Bus. Tel. #_____ Cell # _____ Is Witness an employee? ☐ Yes ☐ No

Company Motor Vehicle Accident Information

Reported to the Police? ☐ Yes ☐ No Police Department Contact _____

Police Report Number _____ No. OF Citations Issued _____ Vehicle Damage ☐ Yes ☐ No

Light Conditions (i.e. dawn, dusk) _____Road Conditions (i.e. wet, dry, icy) _____

Weather conditions (i.e. cloudy, rainy) _____ Approx. Speed_____

employees injured _____ # Non-employee injured _____ # of other vehicles involved _____

License Plate _____ Registration State _____ Vin # _____

Make _____ Model _____ Year _____

Damage Description

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Company Motor Vehicle Report

Where can the vehicle be located? Street _____

City _____ State_____ Tel. No._____

Drivable? ☐ Yes ☐ No Drive's License No. _____ License State _____

Insured? ☐ Yes ☐ No Insur. Policy No._____ Insur. Co. Name_____

Address: Street _____ City _____ State _____ Zip _____

Other Vehicle Driver/Owner Information

License plate _____ Registration State _____ VIN_____

Make _____ Model _____ Year _____

Damage Description

Driver's Name _____ Home Address: Street _____

City _____ State _____ Zip _____

Bus. Tel. No. _____ Cell Tel. No. _____

Driver's License No. _____ Driver's License State _____

If Driver is not the owner, Then enter: Owner's Name _____

Home Address: Street _____ City _____ State _____ Zip _____

Insured ☐ Yes ☐ No Insurance Policy No. _____ Ins. Co. Name _____

Address: Street _____ City _____ State _____ Zip _____

If injured, Injury Description

Passenger Information

Passenger's Name _____ Address: Street _____

City _____ State _____ Zip _____

Home Tel. No. _____ Cell Tel. No. _____

If Injured, Injury Description

_____

_____

☐ Our Vehicle ☐ Other Vehicle

Pedestrian Injury Information

Pedestrian's Name _____ Address: Street _____

City _____ State _____ Zip _____

Home Tel. No. _____ Cell Tel. No. _____ Date Of Birth _____

If Injured, Injury Description

_____

_____

Non-Company Property Damage Other Then Vehicle (Example: Traffic Signs, Guardrails, etc.)

Owners Name _____ Address: Street _____

City _____ State _____ Zip _____

Bus. Tel. No. _____ Cell Tel. No. _____

Property Location _____ Address: Street _____

City _____ State _____ Zip _____

Insured ☐ Yes ☐ No Insurance Policy No. _____ Ins Co. Name _____

Address: Street _____ City _____ Zip _____

Damage Location and Description

_____

_____

☐ Check if more then one other vehicle, Passenger, etc. was involved. Additional forms must be completed.

Show how the accident occurred by filling out of these diagrams.