



STATE OF MONTANA
RISK MANAGEMENT & TORT DEFENSE
DEPARTMENT OF ADMINISTRATION
PO BOX 200124 - HELENA, MT 59620-0124
(406) 444-2421 FAX (406) 444-2592

REPORT OF INCIDENT

COMPLETE ONLY THE SECTION THAT APPLIES TO YOUR LOSS

VEHICLE ☐ PERSONAL INJURY ☐ PROPERTY DAMAGE / OR LOSS ☐

Reporting Person:		Job Title:	
Department:		Division:	Phone:
Date/Time of Incident:	Location of Incident:		

VEHICLE LOSS

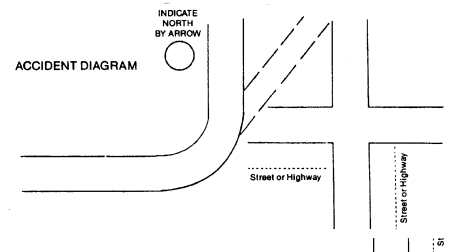
ACCIDENT INFORMATION

Were Police Notified? Yes <input type="checkbox"/> No <input type="checkbox"/>		Police Department Name:
Investigating Officer's Name:		Investigation Officers Phone Number
Were Citations Issued? No <input type="checkbox"/> Yes <input type="checkbox"/> STATE Vehicle Driver <input type="checkbox"/> OTHER Vehicle Driver <input type="checkbox"/>		
Weather Conditions: Clear? <input type="checkbox"/> Rain? <input type="checkbox"/> Snow? <input type="checkbox"/> Other? <input type="checkbox"/> Describe		
Roadway Conditions: Dry? <input type="checkbox"/> Wet? <input type="checkbox"/> Icy? <input type="checkbox"/> Snow packed? <input type="checkbox"/> Other? <input type="checkbox"/> Describe		
Light Conditions: Daylight? <input type="checkbox"/> Darkness? <input type="checkbox"/> Dusk? <input type="checkbox"/> Dawn? <input type="checkbox"/> Other? <input type="checkbox"/> Describe		
Vehicle Speed: STATE Vehicle? OTHER Vehicle?		
License No. _____ Est. Repair _____	Attachment No. _____ Est. Repair _____	Attachment No. _____ Est. Repair _____

Describe Accident/Incident in detail:

Accident Diagram

INDICATE
NORTH
BY ARROW



(use blank paper for additional information)

Signature of Driver:	Date:
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STATE VEHICLE INFORMATION

Department Owning Vehicle:		Phone No.
Driver's Name:		Phone No.
For What Purpose was the Vehicle Being Used?		
Plate No.	VIN No.	Make/Model/Year:
Location Where Vehicle May Be Seen (Address)?		Equip. No.

OTHER VEHICLE INFORMATION						
Plate No./State:		VIN No.:		Make/Model/Year:		
Owner Name:						
Address:					Phone No.:	
Driver's Name:						
Address:					Phone No.:	
Insurance Co.:			Policy No.:		Phone No.:	
OCCUPANTS						
Name:	Address:	Age	State Veh.	Other Veh.	Injured Y - N	Describe Injury
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
WITNESSES						
Name:	Address:			Phone:		
PERSONAL INJURY						
Name of Injured:		Address:			Phone:	
Nature of Injury:						
Describe clearly how accident/injury occurred:						
(use blank paper for additional information)						
PROPERTY DAMAGE / OR LOSS						
State Property <input type="checkbox"/> Other <input type="checkbox"/>						
Describe clearly how property damage occurred:						
(use blank paper for additional information)						
Property Description (Give make, model, serial number when applicable)						
(use blank paper for additional information)						
Date	Reporting Person's Signature:					
Date	Supervisor's Signature:					
Date	Department Official's Signature:					

