



Date of Accident (Mo/Da/Yr)	
Time	<input type="checkbox"/> AM <input type="checkbox"/> PM

INSTRUCTIONS: This report must be mailed within two working days to the following 2 offices:

① Office of Financial Management
Risk Management Division
PO Box 41027
Olympia, WA 98504-1027

② Safety and/or Risk Management
Office of Reporting Agency

STATE EMPLOYEE VEHICLE NO. 1	Name		Age	Employing Agency		Position					
	Business Address			Zip	Business Phone		Was vehicle being used on Official State Business?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Operator's License No.		License Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Indicate		Have you had a previous accident while driving on state business?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	License No.	Year	Make	Body Type	Where Located		No. of Passengers	Est. Repair Cost			
	Owning Agency		Describe Damages Fully (Parts, type and extent of damage)								
If Privately Owned, Name and Address of Owner (If State Owned, Equipment No. Only)							Insurer				
OTHER VEHICLES	Owner Car No. 2			Phone		Owner Car No. 3		Phone			
	Address			City	Zip	Address			City	Zip	
	Driver		Age	Phone		Driver		Age	Phone		
	Address			City	Zip	Address			City	Zip	
	Driver's License No.		Vehicle License No.			Driver's License No.		Vehicle License No.			
	Vehicle Make		Year	Body Type		Vehicle Make		Year	Body Type		
	Name of Passengers					Name of Passengers					
	Repair Cost		Describe Damage			Repair Cost		Describe Damage			
	Insurance Company			Policy No.		Insurance Company			Policy No.		
	OTHER PROPERTY	What was Damaged?						Repair Cost			
Name and Address of Owner				City	Zip	Phone					
INJURED PARTIES	Name and Address				Extent of Injury		Age	Veh. 1	Veh. 2	Veh. 3	Ped.
WITNESSES	Name		Address			City	Zip	Phone			
OTHER RPTS.	Police Investigate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Which Division (Sheriff, WSP, City)		Citation Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No Issued To <input type="checkbox"/> You <input type="checkbox"/> Veh. 2 <input type="checkbox"/> Veh. 3			Have you filed Financial Responsibility Form WSP 161 As Required by Law? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Location	Or Near Intersection of				
City/County	Type of Accident	<input type="checkbox"/> Front to Rear	<input type="checkbox"/> Head-On	<input type="checkbox"/> Parked Car	<input type="checkbox"/> Pedestrian
		<input type="checkbox"/> Broadside	<input type="checkbox"/> Sideswipe	<input type="checkbox"/> Bike - Car	<input type="checkbox"/> Hit Object
Information Regarding Accident	No. 1, Your Vehicle	No. 2, Other Party (Name)	No. 3, Other Party (Name)		
1. If pedestrian, where was he/she (crosswalk, etc.)?					
2. Road conditions (dry, glare, icy, rain, snow, etc.)? (Gravel, blacktop, etc.)					
3. At what distance was danger first noticed?					
4. Speeds at time danger was first noticed?					
5. Speeds at time of accident?					
6. What warning signals were given?					
7. Obstruction to vision (weather and other)?					
8. Lights On? Wipers On? Windows Fogged?					
9. Had any party been drinking? Who?					

Describe in Detail What Happened (Use additional paper if necessary)

<input type="checkbox"/> Straight Road <input type="checkbox"/> Curve - R or L <input type="checkbox"/> Level	<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill	<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane	
Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.			
IMPORTANT If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.			
Indicate points of compass N. E. S. W.			
<div style="text-align: center;">Mark Damaged Areas</div>			
Signature (Driver)	Date	Signature (Supervisor)	Date