

MOTOR VEHICLE ACCIDENT REPORT
 Submit to Weber County Attorney's Office * 2380 Washington Blvd * Ogden, UT, 84401
 County Employees (Drivers) to complete this report immediately

COUNTY EMPLOYEE INVOLVED (driver)	Name			Age	Sex	Dept		Phone		
	Address		City	State	Zip	Home Phone		D L #	Expires	
	For what purpose was Employee driving County vehicle?									
ACCIDENT INFORMATION	Date and time of occurrence			AM PM	Location of accident			City		State
	Law Enforcement Agency whom reported			Investigating Officer			If citation issued, to whom?			
	Provide complete description of accident:									
	(Use reverse side for diagram and additional information)									
COUNTY VEHICLE INVOLVED	Veh #	Year	Make	Model		VIN		License Plate #		
	County Dept responsible for Vehicle			Dept Head Name		Phone		Used with Permission <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Purpose for which being used at time of accident					Was use for this purpose authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Describe Damage									
						Repair Estimate \$		Where is Vehicle located?		
OTHER VEHICLE OR PROPERTY INVOLVED (Use reverse side for additional list or information)	Owners Name		Address			City	State	Zip	Phone	
	Other Driver		Address			City	State	Zip	Phone	
	Drivers License #	State	Insurance Co Name & Address							
	Describe Property (If motor vehicle: year, make, license plate # and VIN)									
	Describe Damage					Repair Estimate \$		Where can property be seen?		
INJURED PERSONS AND NATURE OF ILLNESS	#1 Name		Address				Age	Sex	Phone	
	Nature of Injuries						Injured Driver was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ped			
	Where was injured taken after accident?			By Whom?			Drs. Name & Address			
	Employers Name			Address			Phone		Has injured resumed work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	#2 Name		Address				Age	Sex	Phone	
	Nature of Injuries						Injured Driver was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ped			
	Where was injured taken after accident?			By Whom?			Drs. Name & Address			
	Employers Name			Address			Phone		Has injured resumed work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
WITNESSES	Name		Address			Phone		Passenger? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name		Address			Phone		Passenger? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name		Address			Phone		Passenger? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Signature of County Driver Involved _____ Date _____

Signature of Supervisor _____ Date _____

Signature of Sheriff _____ Date _____