



DATE OF ACCIDENT	M M / D D / Y Y Y Y	S M T W T H F S	TIME OF ACCIDENT (In Military Time)	STATE USE ONLY
	2 0	□ □ □ □ □ □ □ □		

LOCATION OF ACCIDENT	COUNTY	CITY	Total Number of Vehicles Involved
	ROAD ON WHICH ACCIDENT OCCURRED	STREET/HIGHWAY NO. (If no Hwy. No., identify by name)	Posted Speed Limit on the Street You Were Travelling
	DISTANCE FROM MILEPOST FEET	N S E W OF MILEPOST NO.	HIGHWAY NO.
		PRIVATE PROPERTY? YES NO	ONE-WAY STREET? YES NO
		IF AT INTERSECTION	IF NOT AT INTERSECTION
	NAME OF INTERSECTING ROADWAY	OF NEAREST STREET, BRIDGE, RAILROAD CROSSING	
	IF ACCIDENT WAS OUTSIDE CITY LIMITS, INDICATE DISTANCE FROM NEAREST TOWN	MILES N S E W AND MILES	N S E W OF NEAREST CITY OR TOWN

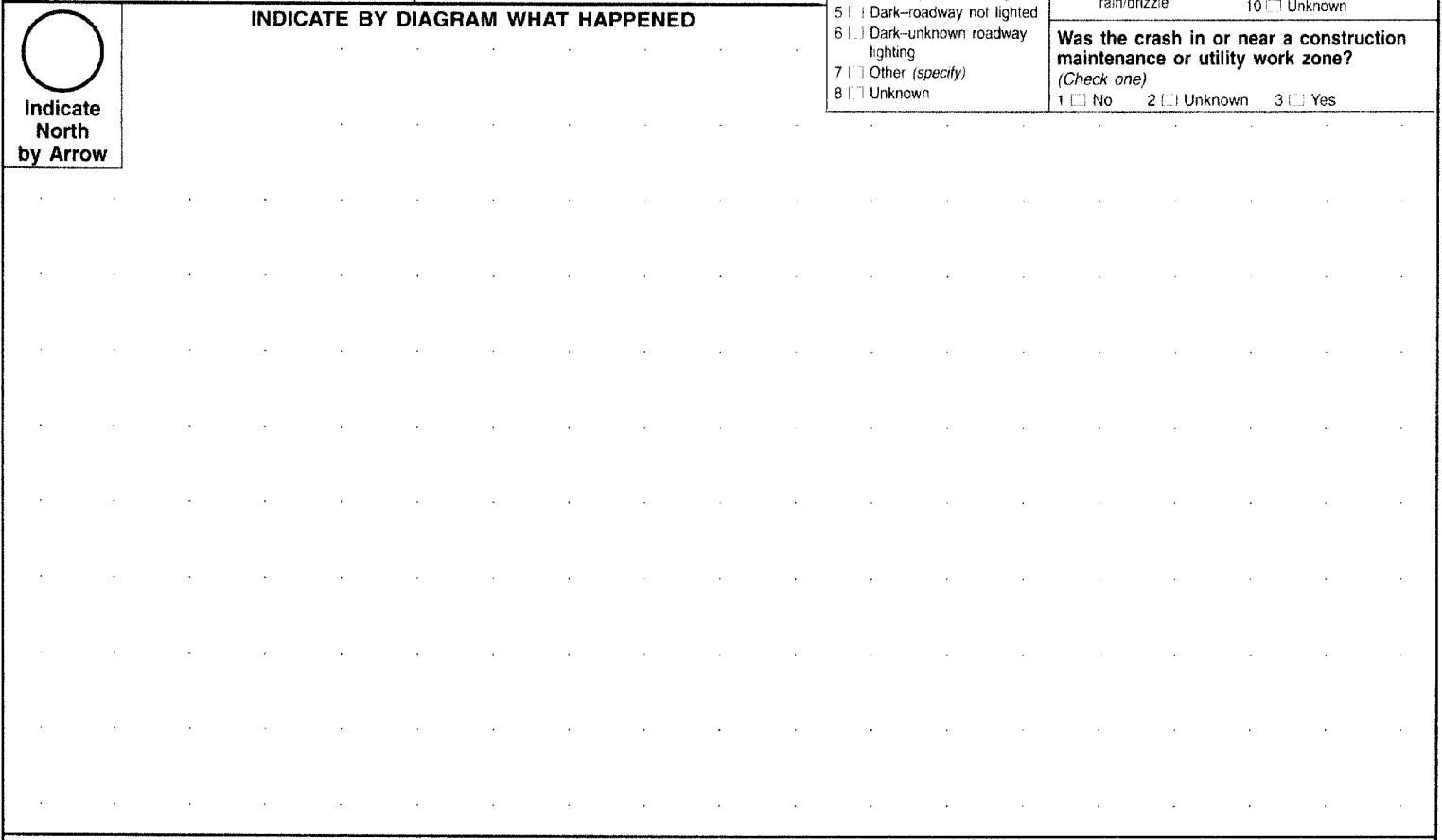
YOUR VEHICLE (VEHICLE NUMBER - 1)				OTHER VEHICLE (VEHICLE NUMBER - 2)			
DRIVER	PHONE	DRIVER	PHONE	DRIVER	PHONE	DRIVER	PHONE
DRIVER ADDRESS	CITY, STATE, ZIP	SEX	DRIVER ADDRESS	CITY, STATE, ZIP	SEX	DRIVER ADDRESS	CITY, STATE, ZIP
DRIVER LICENSE	STATE NUMBER	DATE OF BIRTH	DRIVER LICENSE	STATE NUMBER	DATE OF BIRTH	DRIVER LICENSE	STATE NUMBER
LICENSE PLATE	YEAR (Plate expires)	STATE NUMBER	LICENSE PLATE	YEAR (Plate expires)	STATE NUMBER	LICENSE PLATE	YEAR (Plate expires)
VEHICLE	YEAR MAKE MODEL BODY STYLE COLOR	ESTIMATED DAMAGE \$	VEHICLE	YEAR MAKE MODEL BODY STYLE COLOR	ESTIMATED DAMAGE \$	VEHICLE	YEAR MAKE MODEL BODY STYLE COLOR
VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)	VEHICLE ID NO. (VIN)
OWNER NAME	PHONE	OWNER NAME	PHONE	OWNER NAME	PHONE	OWNER NAME	PHONE
OWNER ADDRESS	CITY, STATE, ZIP	OWNER ADDRESS	CITY, STATE, ZIP	OWNER ADDRESS	CITY, STATE, ZIP	OWNER ADDRESS	CITY, STATE, ZIP

VEHICLE MOVEMENT BEFORE COLLISION		POINT OF IMPACT AND MOST DAMAGED AREA		TRAFFIC CONTROL DEVICE		AIRBAG DEPLOYED		RESTRAINT USE									
VEH NO.	N S E W ROAD OR HIGHWAY NAME	YOUR VEHICLE NO. 1 OTHER VEHICLE NO. 2		(Check one for each vehicle) Vehicle 1 2 1 <input type="checkbox"/> No controls 2 <input type="checkbox"/> Traffic control signal 3 <input type="checkbox"/> Flashing traffic control signal 4 <input type="checkbox"/> School zone signal 5 <input type="checkbox"/> Stop sign 6 <input type="checkbox"/> Yield sign 7 <input type="checkbox"/> Warning sign 8 <input type="checkbox"/> Railroad crossing device 9 <input type="checkbox"/> Unknown		For each person in your vehicle, enter an Airbag Deployed code for their seating position Front: <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>						For each person in your vehicle, enter a Restraint Use code for their seating position Front: <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>					
1		POINT OF IMPACT	POINT OF IMPACT	(Check one for each vehicle) Vehicle 1 2 1 <input type="checkbox"/> Towed - due to damages 2 <input type="checkbox"/> Towed - other reasons 3 <input type="checkbox"/> Left at scene 4 <input type="checkbox"/> Driven away 5 <input type="checkbox"/> Unknown		1 Deployed - front 2 Deployed - side 3 Deployed - both front/side 4 Not deployed 5 Not applicable/ No airbag available 6 Unknown		1 None used 2 Lap & shoulder belt used 3 Shoulder belt only used 4 Lap belt only used 5 Child safety seat used 6 Child booster seat used 7 Helmet used 8 Restraint use unknown									
2		MOST DAMAGED AREA	MOST DAMAGED AREA	Total number of persons in your vehicle													
Vehicle 1 2 01 <input type="checkbox"/> Essentially straight ahead 02 <input type="checkbox"/> Backing 03 <input type="checkbox"/> Changing lanes 04 <input type="checkbox"/> Overtaking/Passing 05 <input type="checkbox"/> Turning right 06 <input type="checkbox"/> Turning left 07 <input type="checkbox"/> Making U-turn 08 <input type="checkbox"/> Entering traffic lane 09 <input type="checkbox"/> Leaving traffic lane 10 <input type="checkbox"/> Parked 11 <input type="checkbox"/> Slowing or stopped in traffic 12 <input type="checkbox"/> Other 13 <input type="checkbox"/> Unknown		00 None 01 <input type="checkbox"/> Top & windows 02 <input type="checkbox"/> Undercarriage 03 <input type="checkbox"/> Total (all areas) 04 <input type="checkbox"/> Other															

Complete this section for all injured persons in your vehicle, also any bicyclists, pedestrians or fatalities involved in the accident. Enter the code number which best answers questions 1- 5 in the appropriate box located at the lower right.

1. Seating Position (Enter one)		2. Ejected/Trapped (Enter one)		3. Body Region with Most Severe Injury (Enter one)		4. Injury Severity (Enter one)		5. Transported to Medical Facility (Enter one)													
10. Other enclosed passenger/cargo area 11. Other unenclosed passenger/cargo area 12. Riding on vehicle exterior 13. Sleeper section of truck cab 14. Trailing unit 15. Moped 16. Motorcycle operator 17. Motorcycle passenger 18. Pedestrian 19. Bicycle (pedalcycle) 20. Unknown		1. Not ejected or trapped 2. Partially ejected 3. Totally ejected 4. Trapped - Occupant removed without use of equipment 5. Trapped - Equipment used in extrication 6. Unknown		01. Head 02. Face 03. Neck 04. Chest 05. Back/spine 06. Shoulder/upper arm 07. Elbow/lower arm/hand 08. Abdomen/pelvis 09. Hip/upper leg 10. Knee/lower leg/foot 11. Entire body 12. Unknown 13. None		1. Killed 2. Disabling - cannot leave scene without assistance (broken bones, severe cuts, prolonged unconsciousness, etc.) 3. Visible but not disabling (minor cuts, swelling, etc.) 4. Possible but not visible (complaint of pain, etc.) 5. None		If the individual was transported from the crash site to a medical facility for treatment of injuries received in the crash: Source of Transport: 1. Not transported 2. EMS (Ambulance) 3. Police 4. Other 5. Unknown													
<table border="1"> <tr><td></td><td>Front</td><td></td></tr> <tr><td>01</td><td>02</td><td>03</td></tr> <tr><td>04</td><td>05</td><td>06</td></tr> <tr><td>07</td><td>08</td><td>09</td></tr> </table>			Front		01	02	03	04	05	06	07	08	09								
	Front																				
01	02	03																			
04	05	06																			
07	08	09																			
NAME	ADDRESS	DATE OF BIRTH (MM / DD / YYYY)	1 Seat Position	2 Eject	3 Body Region	4 Injury Sev.	5 Trans.	SEX	M F												
		/ /																			
NAME	ADDRESS	/ /																			
NAME	ADDRESS	/ /																			
NAME	ADDRESS	/ /																			

Driver Contributing Circumstances <i>(Check one per driver)</i> Vehicle 1 2 01 <input type="checkbox"/> <input type="checkbox"/> No improper driving 02 <input type="checkbox"/> <input type="checkbox"/> Failed to yield right of way 03 <input type="checkbox"/> <input type="checkbox"/> Disregarded traffic signs, signals, road markings 04 <input type="checkbox"/> <input type="checkbox"/> Exceeded authorized speed limit 05 <input type="checkbox"/> <input type="checkbox"/> Driving too fast for conditions 06 <input type="checkbox"/> <input type="checkbox"/> Made improper turn 07 <input type="checkbox"/> <input type="checkbox"/> Wrong side or wrong way 08 <input type="checkbox"/> <input type="checkbox"/> Followed too closely 09 <input type="checkbox"/> <input type="checkbox"/> Failure to keep in proper lane or running off road 10 <input type="checkbox"/> <input type="checkbox"/> Operating vehicle in erratic, reckless, careless, negligent, or aggressive manner 11 <input type="checkbox"/> <input type="checkbox"/> Swerving or avoiding due to wind, slippery surface, vehicle, object, non-motorist in roadway, etc. 12 <input type="checkbox"/> <input type="checkbox"/> Over-correcting/over-steering 13 <input type="checkbox"/> <input type="checkbox"/> Visibility obstructed 14 <input type="checkbox"/> <input type="checkbox"/> Inattention 15 <input type="checkbox"/> <input type="checkbox"/> Mobile phone distraction 16 <input type="checkbox"/> <input type="checkbox"/> Distracted - other 17 <input type="checkbox"/> <input type="checkbox"/> Fatigued/asleep 18 <input type="checkbox"/> <input type="checkbox"/> Operating defective equipment 19 <input type="checkbox"/> <input type="checkbox"/> Other improper action 20 <input type="checkbox"/> <input type="checkbox"/> Unknown	Driver Condition <i>(Check one per driver)</i> Vehicle 1 2 1 <input type="checkbox"/> <input type="checkbox"/> Apparently normal 2 <input type="checkbox"/> <input type="checkbox"/> Physical impairment 3 <input type="checkbox"/> <input type="checkbox"/> Emotional (depressed, angry, disturbed, etc.) 4 <input type="checkbox"/> <input type="checkbox"/> Illness 5 <input type="checkbox"/> <input type="checkbox"/> Fell asleep, fainted, fatigued, etc. 6 <input type="checkbox"/> <input type="checkbox"/> Under the influence of medications/drugs/alcohol 7 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 8 <input type="checkbox"/> <input type="checkbox"/> Unknown	Road Character <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> Straight and level 2 <input type="checkbox"/> <input type="checkbox"/> Straight and on slope 3 <input type="checkbox"/> <input type="checkbox"/> Straight and on hilltop 4 <input type="checkbox"/> <input type="checkbox"/> Curved and level 5 <input type="checkbox"/> <input type="checkbox"/> Curved and on slope 6 <input type="checkbox"/> <input type="checkbox"/> Curved and on hilltop	Road Surface <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> Concrete 2 <input type="checkbox"/> <input type="checkbox"/> Asphalt 3 <input type="checkbox"/> <input type="checkbox"/> Brick 4 <input type="checkbox"/> <input type="checkbox"/> Gravel 5 <input type="checkbox"/> <input type="checkbox"/> Dirt 6 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i>	Road Surface Condition <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> Dry 2 <input type="checkbox"/> <input type="checkbox"/> Wet 3 <input type="checkbox"/> <input type="checkbox"/> Snow 4 <input type="checkbox"/> <input type="checkbox"/> Ice 5 <input type="checkbox"/> <input type="checkbox"/> Sand, mud, dirt, oil, gravel 6 <input type="checkbox"/> <input type="checkbox"/> Water <i>(standing, moving)</i> 7 <input type="checkbox"/> <input type="checkbox"/> Slush 8 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 9 <input type="checkbox"/> <input type="checkbox"/> Unknown
	Road Contributing Circumstances <i>(Check one)</i> 01 <input type="checkbox"/> <input type="checkbox"/> None 02 <input type="checkbox"/> <input type="checkbox"/> Road surface condition (wet, icy, snow, slush, etc.) 03 <input type="checkbox"/> <input type="checkbox"/> Debris 04 <input type="checkbox"/> <input type="checkbox"/> Rut, holes, bumps 05 <input type="checkbox"/> <input type="checkbox"/> Work zone (construction/maintenance/utility) 06 <input type="checkbox"/> <input type="checkbox"/> Worn, travel-polished surface 07 <input type="checkbox"/> <input type="checkbox"/> Obstruction in roadway 08 <input type="checkbox"/> <input type="checkbox"/> Traffic control device inoperative, missing or obscured 09 <input type="checkbox"/> <input type="checkbox"/> Shoulders (none, low, soft, high) 10 <input type="checkbox"/> <input type="checkbox"/> Non-highway work 11 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 12 <input type="checkbox"/> <input type="checkbox"/> Unknown	Environment Contributing Circumstances <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> None 2 <input type="checkbox"/> <input type="checkbox"/> Weather conditions 3 <input type="checkbox"/> <input type="checkbox"/> Vision obstruction 4 <input type="checkbox"/> <input type="checkbox"/> Glare 5 <input type="checkbox"/> <input type="checkbox"/> Animal in roadway 6 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 7 <input type="checkbox"/> <input type="checkbox"/> Unknown	Total Number of Through Lanes <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> One lane 2 <input type="checkbox"/> <input type="checkbox"/> Two lanes 3 <input type="checkbox"/> <input type="checkbox"/> Three lanes 4 <input type="checkbox"/> <input type="checkbox"/> Four lanes 5 <input type="checkbox"/> <input type="checkbox"/> Five lanes 6 <input type="checkbox"/> <input type="checkbox"/> Six or more lanes	Median Type <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> Median barrier 2 <input type="checkbox"/> <input type="checkbox"/> Raised median <i>(curbed)</i> 3 <input type="checkbox"/> <input type="checkbox"/> Grass median <i>(no curb)</i> 4 <input type="checkbox"/> <input type="checkbox"/> Painted <i>(no curb)</i> 5 <input type="checkbox"/> <input type="checkbox"/> None
		Light Condition <i>(Check one)</i> 1 <input type="checkbox"/> <input type="checkbox"/> Daylight 2 <input type="checkbox"/> <input type="checkbox"/> Dawn 3 <input type="checkbox"/> <input type="checkbox"/> Dusk 4 <input type="checkbox"/> <input type="checkbox"/> Dark-lighted roadway 5 <input type="checkbox"/> <input type="checkbox"/> Dark-roadway not lighted 6 <input type="checkbox"/> <input type="checkbox"/> Dark-unknown roadway lighting 7 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 8 <input type="checkbox"/> <input type="checkbox"/> Unknown	Weather Condition <i>(Check up to two)</i> 01 <input type="checkbox"/> <input type="checkbox"/> None 02 <input type="checkbox"/> <input type="checkbox"/> Cloudy 03 <input type="checkbox"/> <input type="checkbox"/> Fog, smog, smoke 04 <input type="checkbox"/> <input type="checkbox"/> Rain 05 <input type="checkbox"/> <input type="checkbox"/> Sleet, hail, freezing rain/drtzzle 06 <input type="checkbox"/> <input type="checkbox"/> Snow 07 <input type="checkbox"/> <input type="checkbox"/> Severe crosswinds 08 <input type="checkbox"/> <input type="checkbox"/> Blowing sand, soil, dirt, snow 09 <input type="checkbox"/> <input type="checkbox"/> Other <i>(specify)</i> 10 <input type="checkbox"/> <input type="checkbox"/> Unknown	



DESCRIBE WHAT HAPPENED (Refer to your vehicle as No. 1, any others as No. 2, No. 3, etc.)

PROPERTY	NON-VEHICLE OBJECT DAMAGED	OWNER NAME	ADDRESS	PHONE () -	APPROX. COST OF DAMAGE \$
	NON-VEHICLE OBJECT DAMAGED	OWNER NAME	ADDRESS	PHONE () -	APPROX. COST OF DAMAGE \$
Was a Police Officer Contacted? <input type="radio"/> YES <input type="radio"/> NO		OFFICER NAME OR BADGE NUMBER		DEPARTMENT <i>(Name of City, County, etc.)</i>	
I certify, to the best of my knowledge, that this report is true and accurate.			OPERATOR SIGNATURE <i>(Required if physically able)</i>		DATE

TO: Department of Motor Vehicles
Financial Responsibility Section
301 Centennial Mall South
PO Box 94789
LINCOLN NE 68059-4789

Please return this form immediately if policy was not in effect as described by motorist.

Do not return form if policy was in effect.

The undersigned company advises that the insurance policy, as described on the reverse side, does not afford liability coverage to both the driver and owner in the limits of \$25,000 - \$50,000 bodily injury and \$25,000 property damage for this accident because of the following reasons:

(please complete)

Name of Insurance Company

Authorized Representative

Date

How to Complete the Back Side of the Accident Report

Answer all of the questions asked about the crash by checking the proper box.

Draw a diagram to show what happened. Provide an explanation of the events which occurred. Instructions on what to show on the diagram are provided below.

If property was damaged, briefly describe it. Enter the owner's name and address and estimate the cost of the damage.

Check whether or not an investigator was contacted. If so, give the officer's name or badge number and the name of their agency.

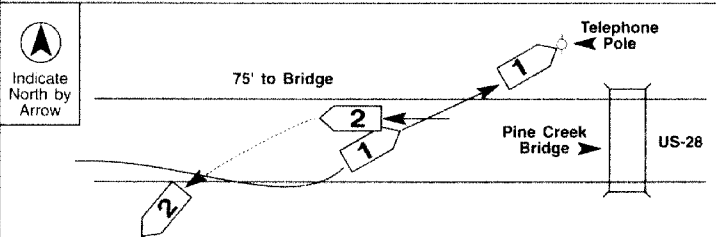
Do not forget to sign the accident report before mailing it to:

Highway Safety - Accident Records Bureau
Nebraska Department of Roads
P.O. Box 94669
Lincoln, NE 68509-4669

What to show on the diagram

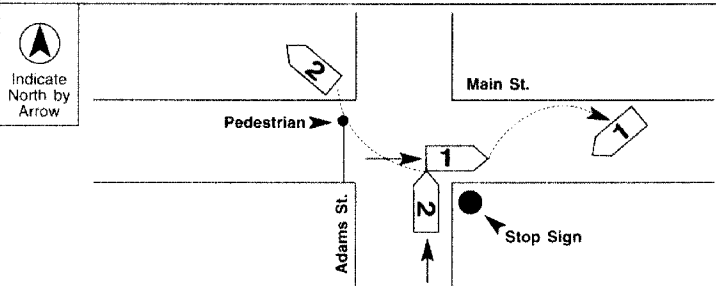
- 1. In the upper left corner, draw an arrow to indicate north.
2. Name all streets and roads.
3. Number each vehicle and use a solid arrow to show the paths the vehicles or pedestrians were traveling before the collision.
4. Draw the vehicle positions at the point of collision.
5. Use a dotted arrow to indicate the post-crash paths of the vehicles, and draw the vehicles where they came to rest.
6. Identify any objects involved (bridges, buildings, guardrail, animals, etc.) If the object was off the roadway, note the distance from the edge of the road.
7. Give distances to landmarks (intersections, mileposts, bridges, railroad crossings, etc.).

Example Diagram: Typical Rural Accident



The right front wheel of No. 1 slipped off the edge of the pavement. While trying to get back on the pavement, the driver turned too sharply and allowed his car to cross the center line where it struck the left rear side of No. 2. Both vehicles left the roadway after the collision and No. 1 then struck a telephone pole.

Example Diagram: Intersection-related Accident



No. 2, going north on Adams Street, failed to stop before entering the intersection with Main Street. No.1 was going east on Main Street. No. 2 struck the right side of No. 1 and No. 2 then went over the curb after striking a pedestrian, who was trying to cross Main Street.

(Remove these Instructions)

You, the driver, must provide information about the liability insurance covering the motor vehicle you were driving. Please complete the following.

Name of Insurance Company Affording Liability Coverage on Date of Accident _____

Address _____

Vehicle Information: VIN No. _____ Year _____ Make _____ Model _____

Name of Agent Who Sold Policy _____ Address _____

Policy No. _____ Date of Accident _____ In or near _____, Nebraska
(Month) (Day) (Year)

Driver _____ Address _____

Owner _____ Address _____

Name of Policyholder _____

SR-21L

State of Nebraska

Driver's Motor Vehicle Accident Report

Questions? 1-402-479-4645

Every operator of a motor vehicle involved in an accident resulting in either injury, death or damages over \$500.00 to the property of any one person (including the operator) must complete and return this confidential report within 10 days following the accident.

If the driver is physically unable to fill out the report, the owner of the motor vehicle is required to do so. If you have difficulty filling out the report, consult your insurance agent or nearest police authority. Failure to report an accident as required is a misdemeanor, punishable by a fine of \$50.00.

Report Form Instructions *(print in ink or type)*

Accident location:

After entering the date, county and city information, describe where the accident occurred. If the crash happened on a numbered rural highway, give the direction and number of feet from the nearest milepost. If your accident occurred on an urban highway, skip the "distance from milepost" section.

If the accident occurred at an intersection, enter the name of the intersecting roadway. For those accidents not located at an intersection, enter the approximate distance in feet from the nearest landmark (intersection, city limit, bridge name, etc.).

Vehicle and driver involvement:

Answer the questions asked about your vehicle and any other vehicle involved in the accident to the best of your ability. If more than two vehicles were involved, complete an additional form(s). Refer to your vehicle as vehicle number 1 throughout the report. Information on bicycles may be entered in the "other vehicle" section.

Be careful when listing the estimated damage to your vehicle. Use a garage estimate whenever possible.

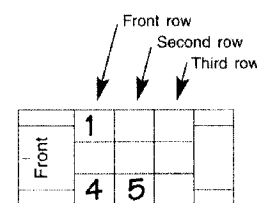
How to enter information about injured persons:

Carefully complete this section for each person injured in your vehicle and any pedestrians or bicyclists injured in the accident. After providing the name, address, date of birth, and sex of each injured person, answer questions 1-5 by writing your response in the appropriate box. If you need to provide injury information for more than four persons, complete another report form.

Airbag deployment coding:

For every occupant in your vehicle, including yourself, enter the correct airbag deployed code according to each person's seating position. For help in marking the car graph see the following example.

Example: There are a total of three occupants in the vehicle, with the driver and one occupant in front, and the third person in the back seat behind the driver. Both the driver and the front passenger seats are equipped with front air bags. The driver's air bag does not deploy during the crash, the front seat passenger's air bag does deploy. The passenger in the backseat does not have an airbag available. The car graph would be marked as shown.

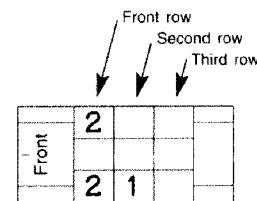


- 1 Deployed - front
- 2 Deployed - side
- 3 Deployed - both front/side
- 4 Not deployed
- 5 Not applicable/
No airbag available
- 6 Unknown

Restraint use coding:

For every occupant in your vehicle, including yourself, enter the correct restraint code according to each person's seating position. For help in marking the car graph, see the following example.

Example: If there were three occupants in the vehicle, with the driver and one occupant in front, both using lap and shoulder belts, and the third occupant in the back seat behind the driver not using any restraint, the car graph would be marked as shown.



- 1 None used - vehicle occupant
- 2 Lap & shoulder belt used
- 3 Shoulder belt only used
- 4 Lap belt only used
- 5 Child safety seat used
- 6 Child booster seat used
- 7 Helmet used
- 8 Restraint use unknown

Example: Assume the car you were driving collided with a bicycle. The bicycle operator was seriously injured and rushed to the hospital. Although you bruised your shoulder and one of your passengers complained of neck pain, no one riding in your vehicle received immediate medical treatment.

NAME	ADDRESS	DATE OF BIRTH (MM / DD / YYYY)	1	2	3	4	5	SEX M F
			Seat Position	Eject	Body Region	Injury Sev.	Trans.	
Sam Public	123 Elm St. Lincoln, NE 68502	10 / 17 / 1993	1, 9		0, 5	2	2	M
Jan Doe	3456 Vermont Ave. Lincoln, NE 68503	07 / 31 / 1964	0, 1	1	0, 6	3	1	F
Mary Doe	3456 Vermont Ave. Lincoln, NE 68503	12 / 30 / 1989	0, 3	1	0, 3	4	1	F
NAME	ADDRESS	/ /						

Complete the back side of the accident Report *(see instructions on the reverse side)*
(Remove these Instructions)