



Department of Public Safety
508-793-2224

College of the Holy Cross Accident Report Form

Date of Accident: _____ Day _____ AM/PM

Number of Vehicles _____

Vehicle 1

Name of Operator: _____

Home Address: _____

Campus Address (if any): _____

Date of Birth: _____ Sex: M/F License #/State: _____

Name of Owner: _____ Phone: _____

Home Address: _____

Vehicle Registration/State: _____ Make: _____ Model: _____

Insurance Company: _____ Estimated Cost to Repair _____

Damage to Car: _____

Vehicle 2

Name of _____

Home Address: _____

Campus Address: _____

Date of Birth: _____

Name of Operator: _____

Home Address: _____

Vehicle Registration/State: _____

Insurance Company: _____

Damage to Car: _____

Property Damage Information

Name of Property Owner: _____ Phone: _____

Home Address: _____

Damage: _____

Name of Witness: _____

Home Address: _____

Name of Witness: _____

Home Address: _____

Passenger Information

Name: _____

Home Address: _____

Name: _____

Home Address: _____

Name: _____

Home Address: _____

Name: _____

Home Address: _____

Init

Name: _____

Home Address: _____

Transportation: _____

Home Address: _____

Name: _____

Home Address: _____

Transportation: _____

Home Address: _____

Name: _____

Home Address: _____

Transportation: _____

Home Address: _____

Statement

Statement

8

9

Please attach any witness statements.

Name of Officer taking report: _____

Accident Diagram

Please draw a diagram of the roadway or indicating the vehicles involved and direction

→ - Direction

1 - Vehicle #1

2 - Vehicle #2

Operator Signature

Date