

OHIO

# TRAFFIC CRASH REPORT



|                                     |                                                                         |                                                        |                                                                   |                                                    |                                                                                                                              |
|-------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| CRASH REPORT #<br><b>10MPD 0479</b> | CRASH SEVERITY<br><b>3</b><br>1 FATAL ERROR 3 FDO<br>2 INJURY 4 UNKNOWN | PRIVATE PROPERTY<br><input type="checkbox"/> 'N IF YES | HITS/SKIP<br><b>1</b><br>1 NOT HIT/SKIP<br>2 SOLVED<br>3 UNSOLVED | PHOTOS TAKEN<br><input type="checkbox"/> 'N IF YES | OH-2 OH-3 OH-1P OTHER<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| N.C.I.C. #<br><b>03801</b>          | REPORTING AGENCY<br><b>MILLERSBURG POLICE DEPARTMENT</b>                | # UNITS<br><b>2</b>                                    | UNIT ERROR<br><b>01</b><br>98 ANIMAL<br>99 UNKNOWN                | DATE OF CRASH<br><b>03/18/2010</b>                 |                                                                                                                              |

|                               |                           |                                         |                                                           |                       |                             |                               |
|-------------------------------|---------------------------|-----------------------------------------|-----------------------------------------------------------|-----------------------|-----------------------------|-------------------------------|
| TIME OF CRASH<br><b>08:20</b> | DAY OF WEEK<br><b>THU</b> | CITY/VILLAGE/TOWNSHIP<br><b>VILLAGE</b> | NAME (OF CITY, VILLAGE OR TOWNSHIP)<br><b>MILLERSBURG</b> | COUNTY #<br><b>38</b> | LATITUDE<br><b>40332304</b> | LONGITUDE<br><b>081550201</b> |
|-------------------------------|---------------------------|-----------------------------------------|-----------------------------------------------------------|-----------------------|-----------------------------|-------------------------------|

|                    |                               |                      |                                                         |  |                   |  |
|--------------------|-------------------------------|----------------------|---------------------------------------------------------|--|-------------------|--|
| CRASH OCCURRED ON  |                               |                      | TYPE LOCATION POINT USED                                |  | LOCAL INFORMATION |  |
| PREFIX<br><b>N</b> | CRASH LOCATION<br><b>CLAY</b> | TYPE LOC<br><b>1</b> | 1 NAMED STREET<br>2 NUMBERED STREET<br>3 NUMBERED ROUTE |  |                   |  |

|                           |                |        |                             |                        |                                                                                         |  |                                                                                                                                                              |
|---------------------------|----------------|--------|-----------------------------|------------------------|-----------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AT/REFERENCE              |                |        |                             | REFERENCE POINT USED   |                                                                                         |  |                                                                                                                                                              |
| DIST. REF.<br><b>50 F</b> | DR<br><b>N</b> | PREFIX | REFERENCE<br><b>PERKINS</b> | REF POINT<br><b>02</b> | 01 STATE LINE<br>02 INTERSECTION OF TWO<br>STREETS<br>03 COUNTY LINE<br>04 HOUSE NUMBER |  | 05 TOWNSHIP BOUNDARY<br>06 MILE POST<br>07 CORPORATION LIMIT<br>08 PLACE NAME WITHOUT<br>REFERENCE<br>09 DRIVEWAY<br>10 STREET OR ROUTE WITHOUT<br>REFERENCE |

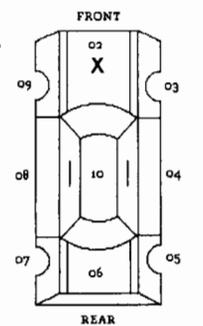
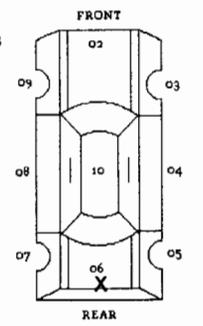
MOTORIST / NON-MOTORIST

|                                                                                         |                         |                                    |                                                                                               |                                                                               |                                        |                                                  |
|-----------------------------------------------------------------------------------------|-------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------|
| <b>A</b>                                                                                | UNIT #<br><b>01</b>     | # OF OCC<br><b>1</b>               | NAME (LAST, FIRST, MIDDLE)<br><b>PINKSTAFF JODY A</b>                                         |                                                                               |                                        |                                                  |
| ADDRESS (STREET, CITY, STATE, ZIP-CODE)<br><b>335 N MILL ST FREDERICKSBURG OH 44627</b> |                         |                                    |                                                                                               |                                                                               |                                        |                                                  |
| SOCIAL SECURITY NUMBER                                                                  |                         | DATE OF BIRTH<br><b>08/18/1968</b> | AGE<br><b>41</b>                                                                              | SEX<br><b>F</b>                                                               | HOME PHONE #<br><b>(330)695-2528</b>   | WORK PHONE #                                     |
| DL STATE<br><b>OH</b>                                                                   | DL #<br><b>QF234048</b> | LP STATE<br><b>OH</b>              | LP #<br><b>EVL3158</b>                                                                        | INJURED TAKEN BY<br><b>1</b><br>1 NONE 4 OTHER<br>2 EMS 5 UNKNOWN<br>3 POLICE | TRANSPORTED BY                         | INJURED TAKEN TO                                 |
| OWNER NAME (IF SAME, WRITE 'SAME')<br><b>PINKSTAFF, JODY A</b>                          |                         |                                    | OWNER ADDRESS (STREET, CITY, STATE, ZIP-CODE)<br><b>335 N MILL ST FREDERICKSBURG OH 44627</b> |                                                                               |                                        |                                                  |
| YEAR<br><b>2004</b>                                                                     | MAKE<br><b>KIA</b>      | MODEL<br><b>OTHER</b>              | COLOR<br><b>GREEN</b>                                                                         | INSURANCE COMPANY<br><b>USAA</b>                                              | TOWING SERVICE<br><b>EMMONS TOWING</b> | OWNER PHONE#                                     |
| OFFENSE CHARGED                                                                         |                         | OFFENSE DESCRIPTION                |                                                                                               |                                                                               | CITATION #                             | LOCAL CODE<br><input type="checkbox"/> 'N IF YES |

|                                                                                   |                         |                                    |                                                                                         |                                                                               |                                      |                                                  |
|-----------------------------------------------------------------------------------|-------------------------|------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------|
| <b>B</b>                                                                          | UNIT #<br><b>02</b>     | # OF OCC<br><b>1</b>               | NAME (LAST, FIRST, MIDDLE)<br><b>SCHERER PATRICIA S</b>                                 |                                                                               |                                      |                                                  |
| ADDRESS (STREET, CITY, STATE, ZIP-CODE)<br><b>582 HARRISON RD SHREVE OH 44676</b> |                         |                                    |                                                                                         |                                                                               |                                      |                                                  |
| SOCIAL SECURITY NUMBER                                                            |                         | DATE OF BIRTH<br><b>04/19/1972</b> | AGE<br><b>37</b>                                                                        | SEX<br><b>M</b>                                                               | HOME PHONE #<br><b>(330)231-4700</b> | WORK PHONE #                                     |
| DL STATE<br><b>OH</b>                                                             | DL #<br><b>RQ424839</b> | LP STATE<br><b>OH</b>              | LP #<br><b>BGA1017</b>                                                                  | INJURED TAKEN BY<br><b>1</b><br>1 NONE 4 OTHER<br>2 EMS 5 UNKNOWN<br>3 POLICE | TRANSPORTED BY                       | INJURED TAKEN TO                                 |
| OWNER NAME (IF SAME, WRITE 'SAME')<br><b>SCHERER, PATRICIA S</b>                  |                         |                                    | OWNER ADDRESS (STREET, CITY, STATE, ZIP-CODE)<br><b>582 HARRISON RD SHREVE OH 44676</b> |                                                                               |                                      |                                                  |
| YEAR<br><b>2005</b>                                                               | MAKE<br><b>CHRYSLER</b> | MODEL<br><b>OTHER</b>              | COLOR<br><b>MAROON</b>                                                                  | INSURANCE COMPANY<br><b>ERIE</b>                                              | TOWING SERVICE                       | OWNER PHONE#                                     |
| OFFENSE CHARGED                                                                   |                         | OFFENSE DESCRIPTION                |                                                                                         |                                                                               | CITATION #                           | LOCAL CODE<br><input type="checkbox"/> 'N IF YES |

|                                         |        |                            |  |                                                                                               |                |                  |     |
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| <b>C</b>                                | UNIT # | NAME (LAST, FIRST, MIDDLE) |  | HOME PHONE#                                                                                   | DATE OF BIRTH  | AGE              | SEX |
| ADDRESS (STREET, CITY, STATE, ZIP-CODE) |        |                            |  | INJURED TAKEN BY<br><input type="checkbox"/><br>1 NONE 4 OTHER<br>2 EMS 5 UNKNOWN<br>3 POLICE | TRANSPORTED BY | INJURED TAKEN TO |     |
| <b>D</b>                                | UNIT # | NAME (LAST, FIRST, MIDDLE) |  | HOME PHONE#                                                                                   | DATE OF BIRTH  | AGE              | SEX |
| ADDRESS (STREET, CITY, STATE, ZIP-CODE) |        |                            |  | INJURED TAKEN BY<br><input type="checkbox"/><br>1 NONE 4 OTHER<br>2 EMS 5 UNKNOWN<br>3 POLICE | TRANSPORTED BY | INJURED TAKEN TO |     |

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| <b>SEATING POSITION</b><br><b>A 01</b><br>01 FRONT - LEFT (MC DRIVER)<br>02 FRONT - MIDDLE<br>03 FRONT - RIGHT<br>04 SECOND - LEFT (MC PASS)<br>05 SECOND - MIDDLE<br>06 SECOND - RIGHT<br>07 THIRD - LEFT (MC PASSENGER SIDE CAR)<br>08 THIRD - MIDDLE<br>09 THIRD - RIGHT<br>10 SLEEPER SECTION OF CAB<br>11 ENCLOSED CARGO AREA<br>12 UNENCLOSED CARGO AREA<br>13 TRAILING UNIT<br>14 EXTERIOR<br>15 OTHER<br>16 NON-MOTORIST<br>17 UNKNOWN<br><b>BLANK FOR WITNESS</b> | <b>SAFETY EQUIPMENT</b><br><b>A 04</b><br>01 NONE USED<br>02 SHOULDER BELT ONLY USED<br>03 LAP BELT ONLY USED<br>04 SHOULDER AND LAP BELT USED<br>05 CHILD SAFETY SEAT USED<br>06 HELMET USED<br>07 RESTRAINT USED UNKNOWN<br><b>B 04</b><br>08 NONE USED<br>09 HELMET USED<br>10 PROTECTIVE PADS<br>11 REFLECTIVE CLOTHING<br>12 LIGHTING<br>13 OTHER<br>14 UNKNOWN | <b>AIR BAG</b><br><b>A 1</b><br>1 NOT DEPLOYED<br>2 DEPLOYED - FRONT<br>3 DEPLOYED - SIDE<br>4 DEPLOYED BOTH FRONT SIDE<br>5 NOT APPLICABLE<br>6 DEPLOYMENT UNKNOWN<br><b>B 1</b><br><b>C</b><br><b>D</b> | <b>AIR BAG SWITCH</b><br><b>A 1</b><br>1 ON-OFF SWITCH NOT PRESENT<br>2 SWITCH IN ON POSITION<br>3 SWITCH IN OFF POSITION<br>4 UNKNOWN POSITION<br><b>B 1</b><br><b>C</b><br><b>D</b> | <b>EJECTION</b><br><b>A 1</b><br>1 NOT EJECTED<br>2 TOTALLY EJECTED<br>3 PARTIALLY EJECTED<br>4 NOT APPLICABLE<br>5 UNKNOWN<br><b>B 1</b><br><b>C</b><br><b>D</b> | <b>TRAPPED</b><br><b>A 1</b><br>1 NOT TRAPPED<br>2 ENTRAPPED BY MECHANICAL MEANS<br>3 FREED BY NON-MECHANICAL MEANS<br>4 UNKNOWN<br><b>B 1</b><br><b>C</b><br><b>D</b> | <b>INJURIES</b><br><b>A 1</b><br>1 NO INJURY<br>2 POSSIBLE<br>3 NON-INCAPACITATING<br>4 INCAPACITATING<br>5 FATAL INJURY<br>6 UNKNOWN<br><b>B 1</b><br><b>C</b><br><b>D</b> |
| <input type="checkbox"/> SUPPLEMENT 'X' IF YES                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                           |                                                                                                                                                                                       |                                                                                                                                                                   |                                                                                                                                                                        |                                                                                                                                                                             |

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| <b>UNIT NUMBERS</b><br>A <input type="text" value="01"/> B <input type="text" value="02"/>        | <b>DAMAGE AREA</b><br>         | <b>PRE-CRASH ACTIONS</b><br>A <input type="text" value="01"/> B <input type="text" value="11"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>SEQUENCE OF EVENTS</b><br><table border="1"> <tr><td>A</td><td>B</td></tr> <tr><td>1 <input type="text" value="20"/></td><td>1 <input type="text" value="20"/></td></tr> <tr><td>2 <input type="text"/></td><td>2 <input type="text"/></td></tr> <tr><td>3 <input type="text"/></td><td>3 <input type="text"/></td></tr> <tr><td>4 <input type="text"/></td><td>4 <input type="text"/></td></tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A                                                                                                  | B                                                                                                                                                                                                                              | 1 <input type="text" value="20"/> | 1 <input type="text" value="20"/> | 2 <input type="text"/> | 2 <input type="text"/> | 3 <input type="text"/> | 3 <input type="text"/>         | 4 <input type="text"/> | 4 <input type="text"/>         | <b>POSTED SPEED</b><br>A <input type="text" value="35"/> B <input type="text" value="35"/> | <b>DRUG TEST STATUS</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/> |
| A                                                                                                 | B                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| 1 <input type="text" value="20"/>                                                                 | 1 <input type="text" value="20"/>                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| 2 <input type="text"/>                                                                            | 2 <input type="text"/>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| 3 <input type="text"/>                                                                            | 3 <input type="text"/>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| 4 <input type="text"/>                                                                            | 4 <input type="text"/>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>NON-MOTORIST LOCATION</b><br>A <input type="text"/>                                            |                               | <b>MOTORIST</b><br>01 MOVEMENTS ESSENTIALLY STRAIGHT AHEAD<br>02 BACKING<br>03 CHANGING LANES<br>04 OVERTAKING-PASSING<br>05 TURNING RIGHT<br>06 TURNING LEFT<br>07 MAKING U-TURN<br>08 ENTERING TRAFFIC LANE<br>09 LEAVING TRAFFIC LANE<br>10 PARKED<br>11 SLOWING OR STOPPED IN TRAFFIC<br>12 DRIVERLESS<br>13 OTHER<br>14 UNKNOWN<br><b>NON-MOTORIST</b><br>15 ENTERING OR CROSSING SPECIFIED LOCATION<br>16 WALKING, RUNNING, JOGGING, PLAYING, CYCLING<br>17 WORKING<br>18 PUSHING VEHICLE<br>19 APPROACHING OR LEAVING VEHICLE<br>20 APPLYING OR WORKING ON VEHICLE<br>21 STANDING BY<br>22 OTHER<br>23 UNKNOWN | <b>NON-COLLISION</b><br>01 OVERTURN/ROLL-OVER<br>02 FIRE/EXPLOSION<br>03 IMMERSION<br>04 JACKKNIFE<br>05 CARGO/EQUIPMENT LOSS OR SHIFT<br>06 EQUIPMENT FAILURE (BLOWN TIRE, BRAKE FAILURE, ETC)<br>07 SEPARATION OF UNITS<br>08 RAN OFF ROAD RIGHT<br>09 RAN OFF ROAD LEFT<br>10 CROSS-MEDIAN CENTERLINE<br>11 DOWNHILL RUNAWAY<br>12 OTHER NON-COLLISION<br>13 UNKNOWN NON-COLLISION<br>14 COLLISION W/ PERSON, VEHICLE, OR OBJECT NOT FINED<br>15 PEST/BEAST<br>16 RAILWAY VEHICLE (E.G. TRAIN, ENGINE)<br>17 ANIMAL - FARM<br>18 ANIMAL - OTHER<br>19 ANIMAL - OTHER<br>20 MOTOR VEHICLE IN TRANSPORT<br>21 PARKED MOTOR VEHICLE<br>22 WORK ZONE MAINTENANCE EQUIPMENT<br>23 OTHER MOVABLE OBJECT<br>24 UNKNOWN MOVABLE OBJECT<br>25 COLLISION WITH FENCED OBJECT<br>26 COLLISION WITH ATOR/CRAASH OBSTACLE<br>27 BRIDGE OVERHEAD STRUCTURE<br>28 BRIDGE PIER OR ABUTMENT<br>29 BRIDGE PARAPET<br>30 BRIDGE RAIL<br>31 GUARDRAIL FACE<br>32 GUARDRAIL END<br>33 MEDIAN BARRIER<br>34 HIGHWAY TRAFFIC SIGN POST<br>35 OVERHEAD SIGN POST<br>36 LIGHT LUMINARIES SUPPORT<br>37 TRAFFIC POLE OR SUPPORT<br>38 UTILITY<br>39 CURB<br>40 DITCH<br>41 EMBANKMENT<br>42 FENCE<br>43 MAILBOX<br>44 TREE<br>45 OTHER FINED OBJECT (WALL, BUILDING, TOWER, ETC)<br>46 WORK ZONE MAINTENANCE EQUIPMENT<br>47 UNKNOWN FINED OBJECT<br>48 OTHER<br>49 UNKNOWN | <b>TRAFFIC CONTROL</b><br>A <input type="text" value="01"/> B <input type="text" value="01"/>      | <b>DRUG TEST TYPE</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>                                                                                                                                     |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>TYPE OF UNIT</b><br>A <input type="text" value="06"/> B <input type="text" value="05"/>        | <b>MOST DAMAGED AREA</b><br>A <input type="text" value="02"/> B <input type="text" value="06"/>                | <b>CONTRIBUTING CIRCUMSTANCES</b><br>A <input type="text" value="08"/> B <input type="text" value="01"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>DIRECTION</b><br>FROM TO<br>A <input type="text" value="1"/> <input type="text" value="2"/> B <input type="text" value="1"/> <input type="text" value="2"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>CONDITION</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>              | <b>DRUG TEST 1 &amp; 2 RESULT</b><br><table border="1"> <tr><td>1</td><td>2</td><td>1</td><td>2</td></tr> <tr><td>A</td><td><input type="text" value="1"/></td><td>B</td><td><input type="text" value="1"/></td></tr> </table> | 1                                 | 2                                 | 1                      | 2                      | A                      | <input type="text" value="1"/> | B                      | <input type="text" value="1"/> |                                                                                            |                                                                                              |
| 1                                                                                                 | 2                                                                                                              | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| A                                                                                                 | <input type="text" value="1"/>                                                                                 | B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="text" value="1"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    |                                                                                                                                                                                                                                |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>IN EMERGENCY RESPONSE</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/> | <b>POINT OF IMPACT</b><br>A <input type="text" value="02"/> B <input type="text" value="06"/>                  | <b>VEHICLE DEFECT CODE ONLY IF '19' SELECTED ABOVE</b><br>A <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>FIRST HARMFUL EVENT</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>ALCOHOL/DRUG SUSPECTED</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/> | <b>TYPE OF INTERSECTION</b><br><input type="text" value="01"/>                                                                                                                                                                 |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>DAMAGE SCALE</b><br>A <input type="text" value="4"/> B <input type="text" value="3"/>          | <b>ACTION</b><br>A <input type="text" value="3"/> B <input type="text" value="4"/>                             | <b>VEHICLE DEFECT CODE ONLY IF '19' SELECTED ABOVE</b><br>A <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>MOST HARMFUL EVENT</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>ALCOHOL TEST STATUS</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>    | <b>ROAD CONTOUR</b><br><input type="text" value="2"/>                                                                                                                                                                          |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>DAMAGE SCALE</b><br>A <input type="text" value="4"/> B <input type="text" value="3"/>          | <b>STRIKING VEHICLE OVERRID/UNDERRIDE</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/> | <b>VEHICLE DEFECT CODE ONLY IF '19' SELECTED ABOVE</b><br>A <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>SPEED DETECTED</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>ALCOHOL TEST TYPE</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/>      | <b>ROAD CONDITIONS</b><br>PRIMARY <input type="text" value="01"/> SECONDARY <input type="text"/>                                                                                                                               |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |
| <b>DAMAGE SCALE</b><br>A <input type="text" value="4"/> B <input type="text" value="3"/>          | <b>STRIKING VEHICLE OVERRID/UNDERRIDE</b><br>A <input type="text" value="1"/> B <input type="text" value="1"/> | <b>VEHICLE DEFECT CODE ONLY IF '19' SELECTED ABOVE</b><br>A <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>SPEED</b><br>A <input type="text" value="30"/> B <input type="text" value="0"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>ALCOHOL TEST RESULT</b><br>A <input type="text"/>                                               | <b>LOCAL REPORT #</b><br>10MPD 0479                                                                                                                                                                                            |                                   |                                   |                        |                        |                        |                                |                        |                                |                                                                                            |                                                                                              |

**NARRATIVE**

UNITS 1 AND 2 WERE SOUTHBOUND ON N CLAY ST. UNIT 1 STOPPED IN TRAFFIC. UNIT 2 STRUCK UNIT 1 IN THE REAR. UNIT 1 WAS DISABLED AND REQUIRED A TOW. UNIT 2 RECEIVED DAMAGE TO THE REAR HATCH DOOR.

|                                                                                                                                                                                                                                                                                              |                                                                                                                                                                              |                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| <b>MANNER OF COLLISION OR IMPACT</b><br><input checked="" type="checkbox"/> <b>2</b><br>1 NOT COLLISION BETWEEN TWO VEHICLES IN TRANSPORT<br>2 REAR-TO-REAR COLLISION<br>3 REAR-TO-REAR BACKING<br>4 ANGLE<br>5 SIDEWIPES SAME DIRECTION<br>6 SIDEWIPES OPPOSITE DIRECTION<br>7 UNKNOWN      | <b>SCHOOL BUS RELATED</b><br><input checked="" type="checkbox"/> <b>1</b><br>1 NO<br>2 YES, DIRECTLY INVOLVED<br>3 YES, INDIRECTLY INVOLVED<br>4 UNKNOWN                     | <b>DIAGRAM</b><br><br> |
| <b>WEATHER</b><br><input checked="" type="checkbox"/> <b>01</b><br>01 CLEAR<br>02 CLOUDY<br>03 FOG/SMOG/SMOKE<br>04 RAIN<br>05 SLIGHT HAIL (FREEZING RAIN OR DRIZZLE)<br>06 SNOW<br>07 SEVERE CROSSWINDS<br>08 BLOWING SAND/DIRT/SNOW<br>09 OTHER<br>10 UNKNOWN                              | <b>WORK ZONE RELATED</b><br><input checked="" type="checkbox"/> <b>1</b><br>1 NO<br>2 YES<br>3 UNKNOWN                                                                       |                        |
| <b>LIGHT CONDITIONS</b><br>PRIMARY <input checked="" type="checkbox"/> <b>1</b> SECONDARY <input type="checkbox"/><br>1 DAYLIGHT<br>2 DAWN<br>3 DUSK<br>4 DARK - LIGHTED ROADWAY<br>5 DARK - ROADWAY NOT LIGHTED<br>6 DARK - UNKNOWN ROADWAY LIGHTING<br>7 HAZARDOUS<br>8 OTHER<br>9 UNKNOWN | <b>TYPE OF WORK ZONE</b><br><input type="checkbox"/><br>1 LANE CLOSURE<br>2 LANE SHIFT/CROSSOVER<br>3 WORK ON SHOULDER OR MEDIAN<br>4 INTERMITTENT OR MOVING WORK<br>5 OTHER |                        |
| <b>LOC. OF CRASH IN WORK ZONE</b><br><input type="checkbox"/><br>1 BEFORE THE FIRST WORK ZONE WARNING SIGN<br>2 ADVANCE WARNING AREA<br>3 TRANSITION AREA<br>4 ACTIVITY AREA                                                                                                                 | <b>WORKERS PRESENT</b><br><input type="checkbox"/><br>1 NO<br>2 YES<br>3 UNKNOWN                                                                                             |                        |

|                                                 |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                           |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>TRUCK/BUS UNIT #</b><br><input type="text"/> | THE CRASH INVOLVED ONE OR MORE OF THE FOLLOWING:<br>A TRUCK (MOTOR VEHICLE) WITH A GVWR MORE THAN 10,000 POUNDS, OR<br>A TRUCK (MOTOR VEHICLE) WITH A HAZARDOUS MATERIALS PLACARD, OR<br>A BUS DESIGNED FOR AT LEAST 8 PERSONS, INCLUDING DRIVER | THE CRASH RESULTED IN ONE OF THE FOLLOWING:<br>A FATALITY, OR<br>AN INJURY REQUIRING TRANSPORTATION OR IMMEDIATE MEDICAL TREATMENT, OR<br>AT LEAST ONE VEHICLE WAS TOWED DUE TO DISABLING DAMAGE OR REQUIRED INTERVENING ASSISTANCE BEFORE PROCEEDING UNDER ITS OWN POWER |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**COMPANY (FROM SHIPPING PAPERS)**

**ADDRESS (STREET, CITY, ST, ZIP CODE)**

|        |        |      |                |                 |              |           |       |
|--------|--------|------|----------------|-----------------|--------------|-----------|-------|
| US DOT | ICC MC | PUCO | TRAILER LP ST. | TRAILER LP YEAR | TRAILER LP # | PLACARD # | # DIA |
|--------|--------|------|----------------|-----------------|--------------|-----------|-------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                       |                                                                                                                                                                  |                                              |                                                                                                                                     |                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CARGO BODY TYPE</b><br><input type="checkbox"/> 01 NOT APPLICABLE<br><input type="checkbox"/> 02 BUS (9-15 INCLUDING DRIVER)<br><input type="checkbox"/> 03 VAN ENCLOSED BOX<br><input type="checkbox"/> 04 GRAIN/CHIPS/GRAVEL<br><input type="checkbox"/> 05 POLE<br><input type="checkbox"/> 06 CARGO TANK<br><input type="checkbox"/> 07 FLATBED<br><input type="checkbox"/> 08 DUMP<br><input type="checkbox"/> 09 CONCRETE MIXER | <input type="checkbox"/> 10 AUTO TRANSPORTER<br><input type="checkbox"/> 11 GARAGE REFUSE<br><input type="checkbox"/> 12 OTHER<br><input type="checkbox"/> 13 UNKNOWN | <b>WEIGHT (GVWR)</b><br><input type="checkbox"/> 1 LESS THAN 10,000<br><input type="checkbox"/> 2 10,001 - 26,000<br><input type="checkbox"/> 3 MORE THAN 26,000 | <b>CDL CLASS</b><br><input type="checkbox"/> | <b>HAZARDOUS MATERIALS</b><br><input type="checkbox"/> 1 NO<br><input type="checkbox"/> 2 YES<br><input type="checkbox"/> 3 UNKNOWN | <b>HAZARDOUS MATERIALS REI FARE#</b><br><input type="checkbox"/> 1 NO<br><input type="checkbox"/> 2 YES<br><input type="checkbox"/> 3 NOT APPLICABLE |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                      |                                                                                                                                                 |                                                |                         |                                        |                    |                            |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------|----------------------------------------|--------------------|----------------------------|
| <b>POLICE ACTION</b>                                                                                                 |                                                                                                                                                 |                                                |                         |                                        |                    |                            |
| <b>DATE CRASH REPORTED</b><br>03/18/2010                                                                             | <b>TIME REC CALL</b><br>08:22                                                                                                                   | <b>DISPATCH</b><br>08:22                       | <b>ARRIVED</b><br>08:23 | <b>CLEARED</b><br>08:57                | <b>OTHER</b><br>25 | <b>TOTAL MINUTES</b><br>60 |
| <b>OFFICER'S NAME</b><br>PTL. JUSTIN ESTILL                                                                          |                                                                                                                                                 | <b>BADGE #</b><br>113                          | <b>CHECKED BY</b>       | <b>DATE REPORT FILED</b><br>03/18/2010 |                    |                            |
| <b>REPORT TAKEN BY</b><br><input checked="" type="checkbox"/> 1 POLICE AGENCY<br><input type="checkbox"/> 2 MOTORIST | <b>REPORT TAKEN AT</b><br><input checked="" type="checkbox"/> 1 SCENE<br><input type="checkbox"/> 2 STATION<br><input type="checkbox"/> 3 OTHER | <input type="checkbox"/> SUPPLEMENT 'X' IF YES |                         | <b>LOCAL REPORT #</b><br>10MPD 0479    |                    |                            |