

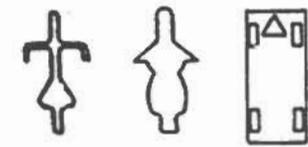
GUAM POLICE DEPARTMENT TRAFFIC ACCIDENT REPORT

ACCIDENT CLASSIFICATION: <input type="checkbox"/> FATAL <input type="checkbox"/> NON-FATAL <input type="checkbox"/> NON-INJURY <input type="checkbox"/> NON-TRAFFIC <input type="checkbox"/> OTHER _____	CASE NO. _____
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ACCIDENT INVOLVED: (CHECK APPROPRIATE BOX)					
<input type="checkbox"/> Automobile(s)	<input type="checkbox"/> Overturn	<input type="checkbox"/> Pedal Cycle	<input type="checkbox"/> Bus	<input type="checkbox"/> Fixed Object	
<input type="checkbox"/> Parked Vehicle	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Truck (Heavy Equipment)	<input type="checkbox"/> Pedestrian	<input type="checkbox"/> Non-Collision	
<input type="checkbox"/> Ran Off Roadway	<input type="checkbox"/> Moped	<input type="checkbox"/> Trailer	<input type="checkbox"/> Animal	<input type="checkbox"/> Other _____	

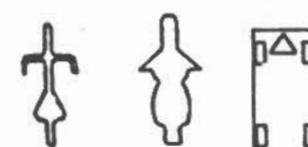
L O C A T I O N	Location _____	<input type="checkbox"/> Rural <input type="checkbox"/> Residential <input type="checkbox"/> Industrial <input type="checkbox"/> Business <input type="checkbox"/> School or Playground <input type="checkbox"/> Open Country <input type="checkbox"/> Other _____
	By _____ Best Area _____	
	Date _____ Time _____ AM/PM Day of Week _____	
	Notified of Accident: Date _____ Time _____ AM/PM	
	Investigation Made: Date _____ Time _____ AM/PM	
	Investigation Elsewhere _____ Date _____ Time _____ AM/PM	
Is the Investigation Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Where Photographs Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No By Whom: _____ I.D. # _____		

VEH#	YEAR	MAKE	MODEL	PLATE #	VIN#	STATE	COLOR
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V E H I C L E S I N V O L V E D	Driver _____ D.O.B. _____ AGE _____ SEX _____	CIRCLE POINT OF IMPACT (SHADE DAMAGED AREAS)  AMOUNT \$ _____ .00 T TOP U UNDERCARRIAGE N NONE
	Home Address _____ Home Phone _____ Race _____	
	Occupation _____ Place of Employment _____	
	DL# _____ Type _____ State _____	
	Restrictions _____ SS# _____ Work Phone _____	
	Insurance _____ Policy No. _____	
	Owner _____ D.O.B. _____ Age _____ Sex _____	
	Address _____ Phone No. _____	
	Vehicle Traveling <input type="checkbox"/> East <input type="checkbox"/> West <input type="checkbox"/> North <input type="checkbox"/> South On _____	
	Impoundment <input type="checkbox"/> Yes <input type="checkbox"/> No Vehicle Moved To _____	
Posted Speed: _____ MPH Driver's Estimated Speed _____ MPH		

YEAR	TRAILER (Other Unit) MAKE	MODEL	PLATE #	VIN#	STATE	COLOR
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YEAR	TRAILER (Other Unit) MAKE	MODEL	PLATE #	VIN#	STATE	COLOR
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CHEMICAL TESTS

1/3 2/4 Pedestrian

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Narcotics Results _____	Where Tested _____	Time _____	By Whom _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Alcohol Results _____	Where Tested _____	Time _____	By Whom _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine Alcohol Results _____	Where Tested _____	Time _____	By Whom _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breath Alcohol Results _____	Where Tested _____	Time _____	By Whom _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Field Sobriety Results _____	Where Tested _____	Time _____	By Whom _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	Where Tested _____	Time _____	By Whom _____

VEHICLE MANEUVER

1/3 2/4

Going Straight

Turn Right to Private Drive

Turning Left to Street

Turning Left to Private Drive

Slowing or Stopped for Signal or Sign

Slowing or Stopped for Entering Traffic

Slowing or Stopped Other

Starting in Traffic

Starting from Parked Position

Stopped in Traffic Lane

Parked Unattended

Backing from Drive Way

Backing from On-Street Parking Space

Entering from Private Roadway

Changing Lanes

Passing

Other _____

WERE SEAT BELTS IN USE?

1/3 2/4

Yes

No

Unknown

MOTORCYCLE HELMET IN USE?

1/3 2/4

Yes

No

Unknown

TYPE OF ACCIDENT

Right Angle

Sideswipe (Same Direction, Opposite Direction)

Head On

Rear End

Turning from Wrong Lane

Left Turn (Opposing Traffic)

Left Turn (Crossing Traffic)

Right Turn (Crossing Traffic)

Object on Roadway

Pedestrian

Other _____

CONDITION OF DRIVER(S) OR PEDESTRIAN(S)

1/3 2/4 Pedestrian

Apparently Normal

Physically Handicapped

Wearing Glasses

Illness

Had Not Been Drinking

Had Been Drinking, and

Ability Impaired

Ability Not Impaired

Unknown Whether Impaired

Other _____

WEATHER CONDITIONS

Clear

Cloudy

Rainy

Storm

Typhoon

Other _____

CONTRIBUTING FACTORS

1/3 2/4

Failure to Yield

Following too Closely

Improper Passing

Improper Turn

Drinking

Speeding

Weather (inclement)

Disregard Stop Sign

Disregard Signal

Wrong Side of Road

Inattention

Avoiding Vehicle, Pedestrian, Object

Vision Obstructed

By _____

Unknown

Other _____

ROAD CHARACTER (Check Two)

1/3 2/4

Curve

Straight

Upgrade

Downgrade

Hill Crest

Dip

Level

Other _____

ROAD DEFECTS

Defective Shoulders

Holes, Deep Ruts

Loose Material on Surface

No Defects

Other _____

ROAD TYPE

1/3 2/4

One Lane

Two Lanes

Three Lanes

Four Lanes

One Way

Merging Lanes

W/Median Lanes

Lanes Under Construction

Other _____

LIGHT CONDITIONS

Dawn

Daylight

Dusk

Dark (Street Lights Off)

Dark (Street Lights On)

Dark (No Street Lights)

TRAFFIC CONTROLS

1/3 2/4

No Control

Stop Sign

Traffic Signal

Flashing Signal

Yield Sign

Police Officer

Flagman

No Passing Zone

Other _____

VEHICLE CONDITION (Check one or more)

1/3 2/4

Defective Brakes

Improper Lights

Defective Steering Mechanism

Defective Tires

No Defects

Tinted Windows

Other _____

PEDESTRIAN

Was Going _____ On _____ Across From _____ TO _____

Direction (N.S.E.W.) Street, Hwy No. (S.E. Corner to N. E. Corner, or West Side to East Side)

<input type="checkbox"/> Crossing at Intersection with Signal	<input type="checkbox"/> Walking on Roadway (Check Two)	<input type="checkbox"/> Working on Roadway
<input type="checkbox"/> Same -Against Signal	1 With Traffic 3 Sidewalks Available	<input type="checkbox"/> Playing on Roadway
<input type="checkbox"/> Same - No Signal	2 Against Traffic 4 Sidewalks Not Available	<input type="checkbox"/> Hitching on Vehicle
<input type="checkbox"/> Same - Diagonally	<input type="checkbox"/> Standing in Safety Zone	<input type="checkbox"/> Not in Roadway (Explain)
<input type="checkbox"/> Crossing not at Intersection	<input type="checkbox"/> Getting on or off Other Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No Were Crosswalks Marked?
<input type="checkbox"/> Coming from behind Parked Cars	<input type="checkbox"/> Pushing or Working on Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No Was Pedestrian Inside Markings?
<input type="checkbox"/> Other _____		<input type="checkbox"/> Yes <input type="checkbox"/> No Extensions of Sidewalk Lines?

