



College of the Holy Cross Accident Report and Investigation Form

Date of Accident: _____ Day of Week: _____ Time: _____ AM/PM

Number of Vehicles Involved: _____ Number of Injured: _____

Vehicle #1

Name of Operator: _____ Phone: _____

Home Address: _____

Campus Address (if any): _____

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

Name of Owner: _____ Phone: _____

Home Address: _____

Vehicle ID # (VIN) **required** _____ Vehicle Registration (Plate) & State: _____

Vehicle Make: _____ Model: _____ Year: _____ Color: _____

Insurance Company: _____ Estimated Cost to Repair: \$ _____

Damage to Car: _____

_____ Seat Belt Used? Y/N Parked? Y/N

Vehicle #2

Name of Operator: _____ Phone: _____

Home Address: _____

Campus Address (if any): _____

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

Name of Owner: _____ Phone: _____

Home Address: _____

Vehicle ID # (VIN) **required** _____ Vehicle Registration (Plate) & State: _____

Vehicle Make: _____ Model: _____ Year: _____ Color: _____

Insurance Company: _____ Estimated Cost to Repair: \$ _____

Damage to Car: _____

_____ Seat Belt Used? Y/N Parked? Y/N

