

Department of Motor Vehicles
 Agency of Transportation
 dmv.vermont.gov

 120 State Street
 Montpelier, Vermont 05603-0001
 802.828.2000

A crash with more than two vehicles involved must fill out as many forms as needed to include all vehicles involved in the crash.

DMV CRASH NUMBER

The operator of every motor vehicle involved in a crash that results in injury or death or total property damage of \$3,000.00 or more (this includes all vehicles involved and physical property damage) must make a report on this form within 72 hours to the above address. You must report even if the vehicle was parked. The failure or refusal of any person to report may be punishable by a civil penalty. Insurance information is required.

Time of Crash <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Day of Week	Date of Crash	Location (City/Town)	Street/Route/Highway of crash
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Your Vehicle		Number of occupants		Other Party		Number of occupants							
Operator name (Last, First, Middle)			Date of Birth		Operator name (Last, First, Middle)			Date of Birth					
Address (street)				Address (street)									
City		State		Zip		City		State		Zip			
License #		License Class		License State		License #		License Class		License State			
VIN			Plate #		Plate State		VIN			Plate #		Plate State	
Vehicle Year	Vehicle Make	Vehicle Model		Vehicle Type		Vehicle Year	Vehicle Make	Vehicle Model		Vehicle Type			
Trailer Year	Trailer Make	Trailer Model		Trailer Plate #		Trailer Year	Trailer Make	Trailer Model		Trailer Plate #			
Commercial Vehicle <input type="checkbox"/> YES <input type="checkbox"/> NO		Hazardous Materials <input type="checkbox"/> YES <input type="checkbox"/> NO		Commercial Vehicle <input type="checkbox"/> YES <input type="checkbox"/> NO		Hazardous Materials <input type="checkbox"/> YES <input type="checkbox"/> NO							

ACTUAL COST OF VEHICLE #1 REPAIRS		IF THE CRASH INVOLVED A PEDESTRIAN OR A BICYCLIST, COMPLETE THE FOLLOWING INFORMATION				ACTUAL COST OF VEHICLE #2 REPAIRS						
PROPERTY DAMAGE OTHER THAN VEHICLE		WHAT WAS PEDESTRIAN OR BICYCLIST DOING				PROPERTY DAMAGE OTHER THAN VEHICLE						
APPROXIMATE COST OF PROPERTY REPAIRS		<input type="checkbox"/> WALKING WITH TRAFFIC	<input type="checkbox"/> WALKING AGAINST TRAFFIC	<input type="checkbox"/> NOT IN ROADWAY	<input type="checkbox"/> CROSSING INTERSECTION	<input type="checkbox"/> PLAYING IN ROAD	<input type="checkbox"/> GETTING ON/OFF VEHICLE	<input type="checkbox"/> PUSHING VEHICLE	<input type="checkbox"/> WORKING ON VEHICLE	<input type="checkbox"/> CROSSING NOT AT AN INTERSECTION	<input type="checkbox"/> RIDING/PUSHING BIKE	<input type="checkbox"/> UNKNOWN
PROPERTY OWNER'S NAME AND ADDRESS:		OTHER:				PROPERTY OWNER'S NAME AND ADDRESS:						
		DESCRIBE INJURY:										

OCCUPANT DATA - the information below is required for yourself and all occupants in all vehicles (attach additional sheets if there is not enough room below)

Occupant's name and address (use the first line for yourself even if not injured)	Nature and extent of injury (state "none" if not injured)	Name of hospital injured taken to	THIS INFORMATION IS REQUIRED					
			Veh no	Position within vehicle	Age of occ.	Gender	Was seatbelt or harness used	Was occupant thrown from vehicle
			1	DRIVER				

Describe in your own words what happened (attach additional pages if necessary)

Did an officer investigate this crash? Yes No If yes, give the name of the officer:
Officers Department:

Were you driving a commercial vehicle? Yes No
Was the vehicle transporting hazardous materials? Yes No If yes, give the name of the material:

I hereby affirm, under penalty of perjury, that the information on this form is true and correct to the best of my knowledge. This declaration made under penalties of 23 VSA § 202 & § 4110.	Signature of Vehicle Owner	Date Signed
	X	

IMPORTANT: YOU MUST FURNISH THE INSURANCE INFORMATION REQUESTED FOR THE VEHICLE YOU WERE OPERATING.

Vermont law requires that any person involved in a crash which has resulted in bodily injury or death to any person or whereby the motor vehicle then under his control or any other property is damaged in an aggregate amount to the extent of \$3,000 or more must furnish the commissioner with satisfactory proof that a standard provisions automobile liability insurance policy was in full force and effect at the time of the crash.

Any person who fails to furnish satisfactory proof that liability insurance was in force at the time of the crash may be required to obtain and furnish proof that Financial Responsibility Insurance has been obtained to cover such person in the future operation of any motor vehicle.

<p>(OPERATOR #1) MUST COMPLETE BOTH SECTIONS BELOW IN FULL. IF YOU FAIL TO GIVE FULL INFORMATION BELOW, IT WILL BE ASSUMED THAT YOU DO NOT HAVE AUTOMOBILE LIABILITY INSURANCE AND A SUSPENSION OF YOUR LICENSE/PRIVILEGE TO OPERATE IN VERMONT WILL BE ISSUED.</p>	DMV CRASH NUMBER
<p>Was an Automobile Liability Insurance policy, providing you AT LEAST \$25,000/\$50,000 bodily injury and \$10,000 property damage insurance in effect on the date of the above crash? You must answer Yes or No. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of your (Operator 1) Insurance Company (NOT AGENT): Insurance _____</p> <p>Company Mailing Address: _____</p> <p>Policy Number: _____ Policy Period From: ____ / ____ / ____ to ____ / ____ / ____</p> <p>Name of Policy Holder: _____ Address: _____</p> <p>Name of Operator at the time of the Crash: _____ Date of Crash: ____ / ____ / ____</p> <p>Is this motor vehicle covered by a Certificate of Self-Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, certificate number: _____</p>	

DO NOT DETACH FORM SR-21A	VERMONT DEPARTMENT OF MOTOR VEHICLES MONTPELIER VERMONT	DMV CRASH NUMBER
<p>Name of insurance company with whom you are insured for liability or damage to others (For Operator #1): _____</p> <p>Insurance Company mailing address: _____</p> <p>Policy Number: _____ Policy Period From: ____ / ____ / ____ to ____ / ____ / ____</p> <p>Date of Crash: ____ / ____ / ____ At or near (Town/City): _____</p> <p>Make of your vehicle: _____ Year: _____ Type: _____ VIN: _____</p> <p>Operator: _____ Address: _____</p> <p>Name of Policy Holder: _____ Signature of Operator: _____</p> <p style="text-align: center; color: red;">IMPORTANT!! THIS CRASH SHOULD ALSO BE REPORTED DIRECTLY TO YOUR INSURANCE COMPANY. FAILURE TO REPORT MAY JEOPARDIZE YOUR AUTOMOBILE LIABILITY</p>		

DO NOT WRITE IN THE SECTION BELOW – IT IS FOR THE USE OF THE INSURANCE COMPANY ONLY

<p>TO INSURANCE COMPANY</p> <p>Return this form within 15 days if no policy or insufficient policy was in effect as alleged by a motorist. If notification is not received within 15 days, it will be assumed the required insurance was in effect at the time of the crash.</p> <p>Send to: COMMISSIONER OF MOTOR VEHICLES, 120 STATE STREET, MONTPELIER, VERMONT 05603-0001</p> <p>Concerning an insurance policy for the policyholder named hereof, the undersigned insurance company advises you in accordance with the items checked below :</p> <p><input type="checkbox"/> 1. No such policy was in effect at the time of the crash.</p> <p><input type="checkbox"/> 2. Our policy affords limits of liability less than \$25,000/\$50,000 bodily injury and \$10,000 property damage (indicate actual limits under remarks).</p> <p>REMARKS: _____</p>		
Name of Insurance Company	Authorized Representative	Date