MINNESOTA MOTOR VEHICLE ACCIDENT REPORT

Every driver in a crash involving $1,000 or more in property damage, or injury or death, MUST COMPLETE this form and send it to Driver and Vehicle Services within 10 days.

Failure to provide this information is a misdemeanor under Minnesota Statute 169.09, subdivision 7. See reverse side for address and for data privacy information.

Driver's Traffic Accident Report

Insurance

Give Full Liability Insurance Information or It Will Be Assumed You Did Not Have Liability Insurance

Please copy policy from automobile insurance company (not agency)

Name of Policy Holder

Address

Your Signature

Other

Other Driver

Other Owner

Driver's License Number

Owner's License Number

License Plate Number

Type (Car, pickup, van, SUV, motorcycle, truck, etc.)

Make

Model

Year

Color

Estimate Cost to Repair

Total Number of Vehicles INVOLVED

Date of Accident

Month

Day

Year

Day of Week

Time

Am

Pm

Location of Accident

On:

[ ] At Intersection

[ ] Not At Intersection

In Parking Lot

Describe Location

Accident Occurred

Driver

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As required by Minnesota Data Privacy Act you are hereby informed that the information requested on this form is collected pursuant to statute to provide statistical data on traffic accidents. The time and place of the accident, names of parties involved and insurance information may be disclosed to any person involved in the accident or to others persons as specified by law. This written report cannot be used against you as evidence in any civil or criminal matter and your version of how the accident happened is confidential.

**SEAT OCCUPANT Seat Position Codes**
1. DRIVER
   (INCLUDE MOTORCYCLE DRIVER)
2. FRONT CENTER
3. FRONT RIGHT
4. SECOND ROW SEAT LEFT
5. SECOND ROW SEAT CENTER
6. SECOND ROW SEAT RIGHT
7. THIRD ROW SEAT LEFT
8. THIRD ROW SEAT CENTER
9. THIRD ROW SEAT RIGHT
10. OUTSIDE OF VEHICLE
11. TRAILING UNIT
12. PICKUP TRUCK BED
13. TRUCK CAB SLEEPER SECTION
14. PASSENGER IN OTHER POSITION
   (INCLUDE MOTORCYCLE PASSENGER)
15. PASSENGER IN UNKNOWN POSITION
16. FRONT LEFT (NON-DRIVER)

**TYPE SAFETY EQUIPMENT Type Codes**
1. NO SAFETY EQUIP IN PLACE
2. LAP BELT
3. SHOULDER BELT
4. LAP & SHOULDER BELT
5. CHILD SAFETY SEAT
6. CHILD BOOSTER SEAT
95. NOT APPLICABLE
   (MOTORCYCLE, SNOWMOBILE, ECT.)

**USE RESTRAINT DEVICE USED CODES**
1. BELTS NOT USED
2. LAP BELT ONLY USED
3. SHOULDER BELT ONLY USED
4. LAP AND SHOULDER BELT USED
5. CHILD SEAT NOT USED
6. CHILD SEAT USED IMPROPERLY
7. CHILD SEAT USED PROPERLY
8. BOOSTER SEAT NOT USED
9. BOOSTER SEAT USED IMPROPERLY
10. BOOSTER SEAT USED PROPERLY
11. HELMET NOT USED
12. HELMET USED

**AIR BAG SAFETY EQUIPMENT USED CODES**
1. DEPLOYED-FRONT
2. DEPLOYED-SIDE
3. DEPLOYED-FRONT AND SIDE
4. NOT DEPLOYED-SWITCH ON
5. NOT DEPLOYED-SWITCH OFF
6. NOT DEPLOYED: UNKNOWN
   IF SWITCH ON OR OFF
95. OTHER DEPLOYMENTS
98. NOT APPLICABLE
   (MOTORCYCLE, SNOWMOBILE, ECT.)

**EJECT EJECTION CODES**
1. TRAPPED, EXTRICATED
   (BY MECHANICAL MEANS)
2. TRAPPED, FREED BY
   NON-MECHANICAL MEANS
3. PARTIALLY EJECTED
4. EJECTED
5. NOT EJECTED OR TRAPPED

**INJURY INJURY CODES**
K- KILLED
A- INCAPACITATING INJURY
B- NON-INCAPACITATING INJURY
C- POSSIBLE INJURY
N- NO APPARENT INJURY

**MY VEHICLE: DRIVER AND PASSENGERS INFORMATION:**

<table>
<thead>
<tr>
<th>DRIVER</th>
<th>DATE OF BIRTH (OR AGE)</th>
<th>SEX</th>
<th>SEAT</th>
<th>TYPE</th>
<th>USE</th>
<th>AIR BAG</th>
<th>EJECT</th>
<th>INJURY</th>
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<tr>
<th>PASSENGER NAME</th>
<th>CITY</th>
<th>STATE</th>
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**DESCRIBE ACCIDENT IN SUFFICIENT DETAIL BELOW TO DISCLOSE CAUSES.**

DESCRIBE WHAT HAPPENED:

DIAGRAM WHAT HAPPENED:

INDICATE NORTH BY ARROW

**DAMAGE TO PROPERTY OTHER THAN VEHICLES: [MAILBOX, FENCE, SIGNPOST, GUARDRAIL, ECT.]**

<table>
<thead>
<tr>
<th>PROPERTY</th>
<th>NAME OF PROPERTY OWNER</th>
<th>ESTIMATE COST OF REPAIR</th>
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</table>

**SIGN HERE X**

SIGNATURE OF PERSON SUBMITTING REPORT IS REQUIRED

ADDRESS

DATE OF REPORT

MAIL THIS REPORT TO:

DVS / ACCIDENT RECORDS
445 MINNESOTA STREET, SUITE 181
ST. PAUL, MN  55101-5181
**DO NOT DETACH**

**THIS SECTION IS TO BE FILLED OUT BY THE HOME OFFICE OF THE INSURANCE COMPANY ONLY**

(Commissioner of Public Safety to forward this form to Insurance Company for verification)

---

**ATTENTION INSURANCE COMPANY:** PLEASE RETURN THIS FORM TO THE ADDRESS BELOW WITHIN 15 DAYS ONLY IF POLICY WAS NOT IN EFFECT AT THE TIME OF THE ACCIDENT.

To: Department of Public Safety  
Driver and Vehicle Services  
Accident Records  
445 Minnesota Street, Suite 181  
St. Paul, Minnesota 55101-5181

We hereby advise you that the policyholder named on the reverse side did NOT have a policy in effect at the time of accident.

Date: __________________________   By: __________________________

Authorized Representative of Insurance Company

---

**DO NOT FILL OUT SHADIED BOX ABOVE - COMPLETE ALL INFORMATION ON SHEET BELOW.**

---

**DRIVER'S TRAFFIC ACCIDENT REPORT**  
E-form available at: www.mncurveinfo.org

---

**A**  
**TIME-PLACE**  
**DATE OF ACCIDENT**  
**MONTH**  
**DAY**  
**YEAR**  
**DAY OF WEEK**  
**TIME**  
**TOTAL # OF VEHICLES INVOLVED**  
**COUNTY**  
**NAME OF CITY OR TOWNSHIP**

**LOCATION OF ACCIDENT**  
**ON:**  
**AT:**  
**LOCATION OF ACCIDENT**  
**AT:**  
**LOCATION OF ACCIDENT**  
**AT:**  
**DESCRIPTION LOCATION**

---

**B**  
**DRIVER/VEHICLE**  
**MY**  
**DATE OF BIRTH**  
**SEX**  
**DRIVER'S FULL NAME**  
**ADDRESS**  
**CITY**  
**STATE**  
**ZIP CODE**  
**INJURY CODE**

**DRIVER'S LICENSE NUMBER**  
**CLASS**  
**STATE OF ISSUE**  
**DATE OF ISSUE**  
**SEX**  
**OWNER'S FULL NAME**  
**ADDRESS**  
**CITY**  
**STATE**  
**ZIP CODE**

**LICENSE PLATE NUMBER**  
**YEAR**  
**STATE OF ISSUE**  
**PARTS OF VEHICLE DAMAGED**

**ESTIMATE COST TO REPAIR**  
**TYPE (CAR, PICKUP, VAN, SUV, MOTORCYCLE, TRUCK, ETC.)**  
**MAKE**  
**MODEL**  
**YEAR**  
**COLOR**  
**# OF OCCUPANTS**

---

**GIVE FULL LIABILITY INSURANCE INFORMATION OR IT WILL BE ASSUMED YOU DID NOT HAVE INSURANCE**

**PLEASE COPY FROM POLICY**  
**NAME OF INSURANCE COMPANY (NOT AGENCY)**

**Automobile Insurance**  
**POLICY NUMBER**

Policy Period: from ________ to ________

Name of Policy Holder __________________________  
Address __________________________

**Your Signature: __________________________**

---