FM-16
(REV 4-03)

N.C Department of Administration
Motor Fleet Management Division
VEHICLE ACCIDENT REPORT

This report must be filed regardless of amount of damages

Driver's License #

Traveler's Insurance Claim #

1. DRIVER & STATE OWNED VEHICLE

Name:			Department:	Office Phone:
Home Address:				Vehicle Color:
Vehicle No:	Year:	Make:	Serial No:	License Plate No:
Describe damage to state owned vehicle:				

II. SECOND PARTY & NON-STATE VEHICLE

Owner:				Driver (if not owner:	
Address:				Address:	
Driver License No:	Home Phone:			Vehicle Color:	Home Phone:
Type Vehicle:	Year:	Make:	License No:	Insurance Co:	Policy No:
Describe damage to non-state vehicle:					

III. INJURED:

Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Describe Injuries:	Describe Injuries:

IV. ACCIDENT

Location: (Street(s), City			County:
Date:	Time:	Investigating Officer:	
Describe accident in detail (use back of form to continue/diagram accident):			

V. WITNESSES

Name:	Name:
Address:	Address:
Return to: Worker's Compensation Administrator: Lisa Wilcox	Signature, state owned vehicle driver:
	Date: