



Commonwealth of Massachusetts Motor Vehicle Crash Operator Report

When should I complete a Crash Report?

M.G.L. Chapter 90, Section 26 requires a person who was operating a motor vehicle involved in a crash in which (i) any person was killed or (ii) injured or (iii) in which there was damage in excess of \$1,000 to any one vehicle or other property, to complete and file a Crash Operator Report with the Registrar within five (5) days after such crash (unless the person is physically incapable of doing so due to incapacity). The person completing the report must also send a copy of the report to the police department having jurisdiction on the way where the crash occurred. If the operator is incapacitated but is not the vehicle's owner, the owner is required to file the crash report within the five (5) days based on his/her knowledge and information obtained about the crash. The Registrar may require the owner or operator to supplement the report and he/she can revoke or suspend the license of any person violating any provision of this legal requirement. A police department is required to accept a report filed by an owner or operator whose vehicle has been damaged in a crash in which another person unlawfully left the scene even if damage to the vehicle does not exceed \$1,000.

How To Complete This Form

Please carefully complete all sections of this form that apply to your crash, circling the answer where appropriate. Illegible reports will be returned to you.

Section A: Crash Location

- Provide the city/town where the crash occurred, the date and time of the crash, and the number of vehicles involved.
- Complete section A1 or A2.
- Use official names of all locations, streets and landmarks.
- Use street name and route #, if applicable.
- Be as precise as possible when describing the location.
- Provide enough information to locate the crash to a specific point, not just a street or roadway.

Section B: Vehicle You Were Driving

- Provide information on your license and the vehicle you were driving.
- Use the codes provided to indicate the cause of the crash.

Section C: You and Your Passengers

- Provide information on you and your passengers at the time of the crash.
- Use the codes provided to indicate occupant information.

Section D: Other Vehicles Involved in the Crash

- Provide information on the other vehicle(s) and operator(s) involved in the crash.
- If more than one vehicle involved, please use additional form completing Section D only.

Section E: Non-Motorist(s) Involved

- Provide information on the non-motorist(s) involved in the crash.
- If more than one non-motorist involved, please use additional form completing Section E only.

Section F: Crash Conditions

- Use the codes provided to indicate the conditions at the time of the crash.

Section G: Crash Diagram

- Draw a diagram of how the crash occurred.
- On the diagram, Vehicle 1 represents your vehicle.

Section H: Witness Information

- List all the people who saw the crash but were not involved.

Section I: Property Damage Information

- Indicate all non-vehicular property that was damaged in the crash.

Section J: Description of What Happened

- Describe the crash including events prior to the crash for your vehicles and all other vehicles.

Section K: Signature

- Please sign and print your name and indicate the date you completed the form.

Where to send completed reports:

Mail or deliver one copy to the local police department or state police in the city or town where the crash occurred.

Mail one copy to your Insurance Company.

Mail one copy to the RMV at the following address:

Registry of Motor Vehicles
Crash Records
P.O. Box 55889
Boston, MA 02205-5889

A. Crash Location

A1. City/Town Where Crash Occurred	A2. Date of Crash	A3. Time of Crash	<input type="checkbox"/> AM <input type="checkbox"/> PM	A4. # Vehicles Involved:
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Please complete Section A1 or A2 below to indicate the location of the crash. If you need additional space to describe the crash location, please use Section J on the last page of this form.

A5. Did the crash occur at an intersection of two or more streets? Yes No

If Yes. **Step 1.** Please indicate the route or roadway where you were travelling when the crash occurred:

Route# _____ Name of Roadway/Street _____

Step 2. What was the name (or names) of the intersecting streets?

Route# _____ Name of Roadway/Street _____

Route# _____ Name of Roadway/Street _____

If No. **Step 1.** Please indicate the route, roadway and address where the crash occurred:

The crash occurred on Route #: _____ at Street or Address Number: _____ on the Street/Roadway known as _____

Step 2. Please provide as much of the following specific location information as possible:

The crash occurred (estimate number of feet) _____ (indicate direction as N/S/E/W) _____

of: a) Mile Marker number _____ . _____ OR: b) Exit Number _____

OR: c) Intersecting Street/Roadway _____ Route# Name of Roadway/Street _____

OR: d) Landmark _____

B. Vehicle You Were Driving

B1. Number of occupants in vehicle (including yourself): _____ **B2.** Was vehicle damage above \$1000? Yes No

B3. Driver's License Number	B4. License State	B5. DOB	B6. Age	B7. Sex	<input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F <input type="checkbox"/> U	B8. License Class	<input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> Unknown <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> M
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B9. Commercial Driver's License Endorsements P (Passenger transport) T (Doubles/Triples)
 H (Hazardous) X (Tank and Hazardous) N (Tank vehicles) S School Bus

B10. Vehicle Travel Direction N S E W

B11. Your Full Name (Last, First, Middle) _____ **B12.** Street Address _____ City _____ State _____ Zip Code _____

B13. Insurance Company	B14. Vehicle Registration #	B15. Reg. Type	B16. Reg. State	B17. Vehicle Year	B18. Vehicle Make
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B19. Indicate your type of vehicle

<input type="checkbox"/> 1 Passenger car	<input type="checkbox"/> 4 Bus (16 or more passengers)	<input type="checkbox"/> 9 Truck tractor (bobtail)	<input type="checkbox"/> 14 Motor home/recreational vehicle	<input type="checkbox"/> 17 All terrain vehicle(ATV)
<input type="checkbox"/> 2 Light truck (van, mini-van, pick-up, sport utility)	<input type="checkbox"/> 5 Bus (9-15 passengers)	<input type="checkbox"/> 10 Tractor/semi-trailer	<input type="checkbox"/> 15 Moped	<input type="checkbox"/> 18 Snowmobile
<input type="checkbox"/> 3 Motorcycle	<input type="checkbox"/> 6 Single-unit truck (2 axles)	<input type="checkbox"/> 11 Tractor/doubles	<input type="checkbox"/> 16 Low Speed Vehicle	<input type="checkbox"/> 97 Other
	<input type="checkbox"/> 7 Single-unit truck (3 or more axles)	<input type="checkbox"/> 12 Tractor/triples		<input type="checkbox"/> 99 Unknown
	<input type="checkbox"/> 8 Truck/trailer	<input type="checkbox"/> 13 Unknown heavy truck		

B20. Full Name of Vehicle Owner (Last, First, Middle) _____ **B21.** Street Address _____ City _____ State _____ Zip Code _____

B22. What Was Your Vehicle Doing Prior to the Crash?

<input type="checkbox"/> 1 Travelling straight ahead	<input type="checkbox"/> 3 Turning right	<input type="checkbox"/> 5 Changing lanes	<input type="checkbox"/> 8 Making U-turn	<input type="checkbox"/> 11 Parked
<input type="checkbox"/> 2 Slowing or stopped	<input type="checkbox"/> 4 Turning left	<input type="checkbox"/> 6 Entering traffic lane	<input type="checkbox"/> 9 Overtaking/passing	<input type="checkbox"/> 97 Other
		<input type="checkbox"/> 7 Leaving traffic lane	<input type="checkbox"/> 10 Backing	<input type="checkbox"/> 99 Unknown

B23. Please Indicate the Sequence of Events as they occurred to YOUR Vehicle by writing the corresponding number (1-52, or 97, 99) in up to 4 boxes below.

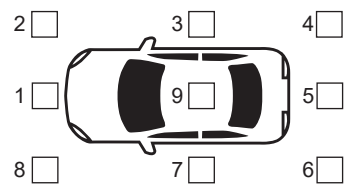
What happened first?	Second?	Third?	Fourth?
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- | | | | | | |
|--|--|--|---|---|---|
| Collision with | 9 Railway vehicle (train, engine) | 25 Median barrier | 32 Crash cushion/ Impact attenuator | Non-Collision | 47 Jackknife |
| 1 Motor vehicle in traffic | 10 Other movable object | 26 Ditch | 33 Bridge | 40 Ran off road right | 48 Cargo/equipment loss or shift |
| 2 Parked motor vehicle | 11 Unknown movable object | 27 Embankment/ Sloping shoulder | 34 Bridge overhead structure | 41 Ran off road left | 49 Separation of units |
| 3 Pedestrian | 20 Curb | 28 Highway traffic signpost | 35 Other fixed object (wall, building, tunnel) | 42 Cross median/ centerline | 50 Downhill runaway |
| 4 Cyclist | 21 Tree | 29 Overhead sign support | 36 Unknown fixed object | 43 Overturn/rollover | 51 Other non-collision |
| 5 Animal- deer | 22 Utility pole | 30 Fence | | 44 Equipment failure (blown tire, brakes, etc) | 52 Unknown non-collision |
| 6 Animal- other | 23 Light pole or other post/support | 31 Mailbox | | 45 Fire/explosion | 97 Other |
| 7 Moped | 24 Guardrail | | | 46 Immersion | 99 Unknown |
| 8 Work zone maintenance equipment | | | | | |

B24. Was your Vehicle Towed from the Scene Due to Damage? Yes No

B25. Vehicle Damaged Area (check up to three)

<input type="checkbox"/> 0 None	<input type="checkbox"/> 97 Other
<input type="checkbox"/> 10 Undercarriage	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 11 Totaled	



C. You and Your Passengers

Please provide the full name, address, and DOB or Age for all passengers in your vehicle. Then write the corresponding code in each of the boxes for each occupant of the vehicle (yourself and all passengers). A list of the possible codes is provided at the bottom of this section.

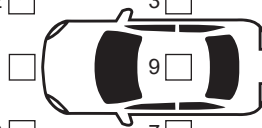
C1. Passenger 1 (Last, First, Middle)	C2. Address	City	State	Zip Code	C3. DOB	C4. Sex
C5. Passenger 2 (Last, First, Middle)	C6. Address	City	State	Zip Code	C7. DOB	C8. Sex
C9. Passenger 3 (Last, First, Middle)	C10. Address	City	State	Zip Code	C11. DOB	C12. Sex

	Seating Position	Safety System Used	Air Bag Status	Ejected From Vehicle?	Trapped?	Injured?	Transported for Medical Care?	Name of Medical Facility
Driver								
Passenger 1								
Passenger 2								
Passenger 3								

Seating Position 1 Front seat - left side (or motorcycle driver) 2 Front seat - middle 3 Front seat - right side 4 Second seat - left side (or motorcycle passenger) 5 Second seat - middle 6 Second seat - right side 7 Third row - left side (or motorcycle passenger) 8 Third row - middle 9 Third row - right side 10 Sleeper section of cab 11 Enclosed passenger area 12 Unenclosed passenger area 13 Trailing unit 14 Riding on vehicle exterior 97 Other 99 Unknown		Safety System Used 0 None used 1 Shoulder and lap belt 2 Lap belt only 3 Shoulder belt only 4 Child safety seat 5 Helmet 97 Unknown		Air Bag Status 1 Deployed-front 2 Deployed-side 3 Deployed both front and side 4 Not deployed 5 Not applicable 97 Unknown	
Ejected From Vehicle? 0 Not ejected 1 Totally ejected 2 Partially ejected 3 Not applicable 97 Unknown		Trapped? 0 Not trapped 1 Freed by mechanical means 2 Freed by non-mechanical means 97 Unknown		Injured? 1 Fatal 7 Suspected serious injury 8 Suspected minor injury 9 Possible Injury 10 No apparent injury	
				Transported for Medical Care? 1 Not transported 2 EMS (emergency service) 3 Police 97 Other 99 Unknown	

D. Other Vehicle(s) Involved in the Crash

D1. Number of occupants in the Vehicle:	D2. Number of injured occupants	D3. Was Vehicle Damage above \$1000? <input type="checkbox"/> Yes <input type="checkbox"/> No		D4. Moped? <input type="checkbox"/> Yes <input type="checkbox"/> No	D5. Hit and Run? <input type="checkbox"/> Yes <input type="checkbox"/> No
D6. Driver's License Number	D7. License State	D8. DOB	D9. Age	D10. Sex <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F <input type="checkbox"/> U	D11. License Class <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> Unknown <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> M
D12. Commercial Driver's License Endorsements <input type="checkbox"/> P (Passenger transport) <input type="checkbox"/> T (Doubles/Triples) <input type="checkbox"/> H (Hazardous) <input type="checkbox"/> X (Tank and Hazardous) <input type="checkbox"/> N (Tank vehicles) <input type="checkbox"/> S School Bus				D13. Vehicle Travel Direction <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W	
D14. Name of Vehicle Driver (Last, First, Middle)		D15. Street Address		City	State Zip Code
D16. Insurance Company	D17. Vehicle Registration #	D18. Reg. Type	D19. Reg. State	D20. Vehicle Year	D21. Vehicle Make
D22. Indicate your type of vehicle <input type="checkbox"/> 1 Passenger car <input type="checkbox"/> 2 Light truck (van, mini-van, pick-up, sport utility) <input type="checkbox"/> 3 Motorcycle <input type="checkbox"/> 4 Bus (16 or more passengers) <input type="checkbox"/> 5 Bus (9-15 passengers) <input type="checkbox"/> 6 Single-unit truck (2 axles) <input type="checkbox"/> 7 Single-unit truck (3 or more axles) <input type="checkbox"/> 8 Truck/trailer		<input type="checkbox"/> 9 Truck tractor (bobtail) <input type="checkbox"/> 10 Tractor/semi-trailer <input type="checkbox"/> 11 Tractor/doubles <input type="checkbox"/> 12 Tractor/triples <input type="checkbox"/> 13 Unknown heavy truck		<input type="checkbox"/> 14 Motor home/recreational vehicle <input type="checkbox"/> 15 Moped <input type="checkbox"/> 16 Low Speed Vehicle <input type="checkbox"/> 17 All terrain vehicle(ATV) <input type="checkbox"/> 18 Snowmobile <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown	
D23. Full Name of Vehicle Owner (Last, First, Middle)		D24. Street Address		City	State Zip Code

D25. What Was Your Vehicle Doing Prior to the Crash? <input type="checkbox"/> 1 Travelling straight ahead <input type="checkbox"/> 2 Slowing or stopped <input type="checkbox"/> 3 Turning right <input type="checkbox"/> 4 Turning left <input type="checkbox"/> 5 Changing lanes <input type="checkbox"/> 6 Entering traffic lane <input type="checkbox"/> 7 Leaving traffic lane <input type="checkbox"/> 8 Making U-turn <input type="checkbox"/> 9 Overtaking/passing <input type="checkbox"/> 10 Backing <input type="checkbox"/> 11 Parked <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown			D26. Vehicle Damaged Area (check up to three) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 1 <input type="checkbox"/> 9 <input type="checkbox"/> 5 <input type="checkbox"/> 8 <input type="checkbox"/> 7 <input type="checkbox"/> 6 <input type="checkbox"/>  <input type="checkbox"/> 0 None <input type="checkbox"/> 10 Undercarriage <input type="checkbox"/> 11 Totaled <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown		
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E. Non-Motorist(s) Involved in the Crash

E1. Indicate the type of non-motorist involved 1 Pedestrian 2 Cyclist 3 Skater 97 Other 99 Unknown

<p>E2. What was the non-motorist doing prior to the crash?</p> <input type="checkbox"/> 1 Entering or crossing location <input type="checkbox"/> 2 Walking, running, or cycling <input type="checkbox"/> 3 Working <input type="checkbox"/> 4 Pushing vehicle <input type="checkbox"/> 5 Approaching or leaving vehicle <input type="checkbox"/> 6 Working on vehicle <input type="checkbox"/> 7 Standing <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown	<p>E3. Where was the non-motorist prior to the crash?</p> <input type="checkbox"/> 1 Marked crosswalk at intersection <input type="checkbox"/> 2 At intersection but no crosswalk <input type="checkbox"/> 3 Non-intersection crosswalk <input type="checkbox"/> 4 In roadway <input type="checkbox"/> 5 Not in roadway <input type="checkbox"/> 6 Median (but not on shoulder) <input type="checkbox"/> 7 Island <input type="checkbox"/> 8 Shoulder <input type="checkbox"/> 9 Sidewalk <input type="checkbox"/> 10 Shared-use path or trails <input type="checkbox"/> 99 Unknown
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E4. Full Name of Non-Motorist (Last, First, Middle) **E5.** Street Address City State Zip Code **E6.** DOB **E7.** Sex

<p>E8. Safety Equipment?</p> <input type="checkbox"/> 0 None used <input type="checkbox"/> 6 Helmet <input type="checkbox"/> 7 Protective pads (elbows, knees, etc.) <input type="checkbox"/> 8 Reflective clothing <input type="checkbox"/> 9 Lighting <input type="checkbox"/> 10 Other <input type="checkbox"/> 99 Unknown	<p>E9. Injured?</p> <input type="checkbox"/> 1 Fatal <input type="checkbox"/> 7 Suspected serious injury <input type="checkbox"/> 8 Suspected minor injury <input type="checkbox"/> 9 Possible Injury <input type="checkbox"/> 10 No apparent injury	<p>E10. Transported for Medical Care?</p> <input type="checkbox"/> 1 Not transported <input type="checkbox"/> 2 EMS (emergency service) <input type="checkbox"/> 3 Police <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown
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E11. If transported, please indicate Hospital/Medical Facility:

F. Crash Conditions

<p>F1. Light Conditions</p> <input type="checkbox"/> 1 Daylight <input type="checkbox"/> 2 Dawn <input type="checkbox"/> 3 Dusk <input type="checkbox"/> 4 Dark - lighted roadway <input type="checkbox"/> 5 Dark - roadway not lighted <input type="checkbox"/> 6 Dark - unknown roadway lighting <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown	<p>F2. Weather Conditions (up to two)</p> <input type="checkbox"/> 1 Clear <input type="checkbox"/> 2 Cloudy <input type="checkbox"/> 3 Rain <input type="checkbox"/> 4 Snow <input type="checkbox"/> 5 Sleet, hail, freezing rain <input type="checkbox"/> 6 Fog, smog, smoke <input type="checkbox"/> 7 Severe crosswinds <input type="checkbox"/> 8 Blowing sand, snow <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown	<p>F3. Traffic Control Device</p> <input type="checkbox"/> 1 No controls <input type="checkbox"/> 2 Stop signs <input type="checkbox"/> 3 Traffic control signal <input type="checkbox"/> 4 Flashing traffic control signal <input type="checkbox"/> 5 Yield signs <input type="checkbox"/> 6 School zone signs <input type="checkbox"/> 7 Warning signs <input type="checkbox"/> 8 Railroad crossing device <input type="checkbox"/> 99 Unknown	<p>F4. Road Surface</p> <input type="checkbox"/> 1 Dry <input type="checkbox"/> 2 Wet <input type="checkbox"/> 3 Snow <input type="checkbox"/> 4 Ice <input type="checkbox"/> 5 Sand, mud, dirt, oil, gravel <input type="checkbox"/> 6 Water (standing, moving) <input type="checkbox"/> 7 Slush <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown
<p>F5. Trafficway Description</p> <input type="checkbox"/> 1 Two-way, not divided <input type="checkbox"/> 2 Two-way, divided, unprotected median <input type="checkbox"/> 3 Two-way, divided, protected median <input type="checkbox"/> 4 One-way, not divided <input type="checkbox"/> 99 Unknown	<p>F6. Manner of Collision</p> <input type="checkbox"/> 1 Single vehicle crash <input type="checkbox"/> 2 Rear-end <input type="checkbox"/> 3 Angle <input type="checkbox"/> 4 Sideswipe, same direction <input type="checkbox"/> 5 Sideswipe, opposite direction <input type="checkbox"/> 6 Head on <input type="checkbox"/> 7 Rear to rear <input type="checkbox"/> 99 Unknown	<p>F7. Roadway Intersection Type</p> <input type="checkbox"/> 1 Not at intersection <input type="checkbox"/> 2 Four-way intersection <input type="checkbox"/> 3 T-intersection <input type="checkbox"/> 4 Y-intersection <input type="checkbox"/> 5 On ramp <input type="checkbox"/> 6 Off ramp <input type="checkbox"/> 7 Traffic circle <input type="checkbox"/> 8 Five-point or more <input type="checkbox"/> 9 Driveway <input type="checkbox"/> 10 Railway grade crossing <input type="checkbox"/> 99 Unknown	

F8. Was the traffic control device functioning at the time of the crash? Yes No **F9.** School Bus Related? Yes No **F10.** Work Zone Related? Yes No

G. Crash Diagram

	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Indicate North by Arrow </div> <p>Please draw a diagram of the roadway or streets where the crash occurred, indicating the vehicles involved and direction of travel using the following symbols:</p> <p style="text-align: center;">Direction</p> <p>1 = Vehicle 1 (Your Vehicle) 2 = Vehicle 2 = Pedestrian/Non-motorist = North</p> <p>Select one of the following if the crash did not occur on a public way:</p> <input type="checkbox"/> Off-street parking lot <input type="checkbox"/> Garage <input type="checkbox"/> Mall/shopping center <input type="checkbox"/> Other private way
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H. Witness Information

H1. Witness Name (Last, First, Middle)	H2. Street Address	City	State	Zip Code	H3. Phone
H4. Witness Name (Last, First, Middle)	H5. Street Address	City	State	Zip Code	H6. Phone

I. Property Damage Information (Other than Vehicles)

I1. Owner Name (Last, First, Middle)	I2. Street Address	I3. Phone	I4. Property and Damage Description
I5. Owner Name (Last, First, Middle)	I6. Street Address	I7. Phone	I8. Property and Damage Description

J. Description of What Happened**K. Signature**

"Signed under Pains and Penalties of Perjury"

Print

Date
