

# CITY OF TULSA OPERATOR'S TRAFFIC COLLISION REPORT FORM



**INSTRUCTIONS:**

1. State law requires that vehicle drivers must immediately stop at the scene, render aid and exchange information when involved in a traffic collision.
2. Obtain drivers license and insurance information from the other driver's Drivers License and Security Verification Form.
3. Complete all information on both sides of this report form. Type or print with black ink.
4. Your information should be listed in the Unit 1 section. Information for the other vehicle shall be indicated as Unit 2.
5. Use additional report forms when more than two (2) vehicles are involved. Change unit numbers to 3,4, etc.
6. Contact your insurance company as soon as possible.
7. Completed report forms should be sent to the Tulsa Police Department at the address listed on the bottom of the report form within 24 hours.

Date of Collision		Day of Week		Time		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Did a Police Officer respond to the collision? <input type="checkbox"/> Yes <input type="checkbox"/> No		Officer's Name			
Street Location of Collision						Was your view blocked by anything at the time of the collision? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain					
Total Number of vehicles involved		Weather Conditions at the time of the collision				Approximate cost to repair your vehicle \$					
Your Name (Unit 1)					Other Driver (Unit 2)						
Last Name		First		Middle	Last Name		First		Middle		
Home Address		City		State	Zip	Home Address		City		State	Zip
Business Address					Business Address						
Home Phone			Business Phone		Home Phone			Business Phone			
Date of Birth		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Injured <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Injured <input type="checkbox"/> Yes <input type="checkbox"/> No		
Driver's License Number			State	Mo/Year of Expiration	Driver's License Number			State	Mo/Year of Expiration		
Vehicle Year	Make	Model		Color		Vehicle Year	Make	Model		Color	
Vehicle License Number		State	Mo/Year of Expiration	Vehicle License Number		State	Mo/Year of Expiration				
Vehicle Owner's Name <input type="checkbox"/> Same as Driver					Vehicle Owner's Name <input type="checkbox"/> Same as Driver						
Owner's Address			Phone		Owner's Address			Phone			
Insurance Company					Insurance Company						
Policy Number		Effective Date	Date of Expiration		Policy Number		Effective Date	Date of Expiration			
Insurance Agent		Address			Insurance Agent		Address				
How fast were you driving prior to the collision? MPH		What was the posted Speed Limit? MPH		What is your estimated speed of the other vehicle? MPH		What was the other vehicle's Posted Speed Limit? MPH					
Passenger Name			Address			Phone		Age	<input type="checkbox"/> "X" if Injured	Riding in Unit Number	
1.											
2.											
3.											
4.											
5.											
6.											
Witness Name				Address				Phone			
1.											
2.											
3.											
4.											
Signature					Date		Time		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		

Note: The reporting of false or fraudulent information may result in criminal and/or civil prosecution.

Completed report forms should be returned to:  
**Tulsa Police Department**  
**Records Division**  
**600 Civic Center**  
**Tulsa, OK. 74103**  
**(918) 596-9288**

- Place an "X" in the appropriate squares for each vehicle.
- Unit 1 refers to your vehicle. Unit 2 refers to the other vehicle. Change Unit numbers to 3,4, etc. for additional vehicles.
- Explain in the Remarks section any boxes checked "other". Give specific details in regard to any sections which are indicated with \*.

Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		O E D L	Condition of Drivers and Pedestrians			
What Vehicles Were Going To Do		What Vehicles Did		Type of Road		Traffic Control		Road Character								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apparently Normal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Drinking-Ability Impaired
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Odor of Alcoholic Beverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Drug Use Indicated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very Tired
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Sick
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Condition Not Known
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Body Defects (arm, leg, eyes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Point of FIRST Contact on Vehicles (check only one for each vehicle)				Light		Weather		What Pedestrian was Doing	
Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2	
		Bottom of Unit # _____				Daylight		Crossing at intersection	
		Top of Unit # _____				Darkness		Crossing/not at intersection	
		1 Front Center		7 Rightside Center		Dark/Lighted		Crossing/at other crosswalk	
		2 Front Right		8 Rightside Forward		Dawn		Getting on/off vehicle	
		3 Front Left		9 Rightside Rear		Dusk		Walking with traffic	
		4 Rear Center		10 Leftside Center		Other		Walking against traffic	
		5 Rear Right		11 Leftside Forward				Pushing on vehicle	
		6 Rear Left		12 Leftside Rear				Working on vehicle	
								Playing	
								Other working *	
								Other	

Object Struck by Vehicle on FIRST Contact (If different than OTHER VEHICLE)				Road Condition		Road Surface		Locality		Vehicle Condition (Indicate Defects*)	
Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2		Unit 1 2	
		Street Light Pole		Dry		Concrete		Residential		Apparently Normal	
		Other Utility Pole		Wet		Asphalt		Business		Brakes	
		Guard Rail		Ice		Gravel		Industrial		Headlights	
		Culvert		Snow		Dirt		School		Steering	
		Traffic Signal		Muddy		Other		Not built up		Tail Lights	
		Barrier		Other				Other		Brake Lights	
		Curb								Tires/Wheels	
		Island								Suspension	
		Traffic Control Sign								Other	
		Sand Barrels									
		Attenuators									
		Pavement Drop-off									
		Ditch									
		Embankment									

**COLLISION DIAGRAM:** Illustrate all involved vehicles to indicate their position before, at and after impact. Draw an arrow to indicate direction of vehicle movement. Draw roadway edges and all lane markings. Label all street names.

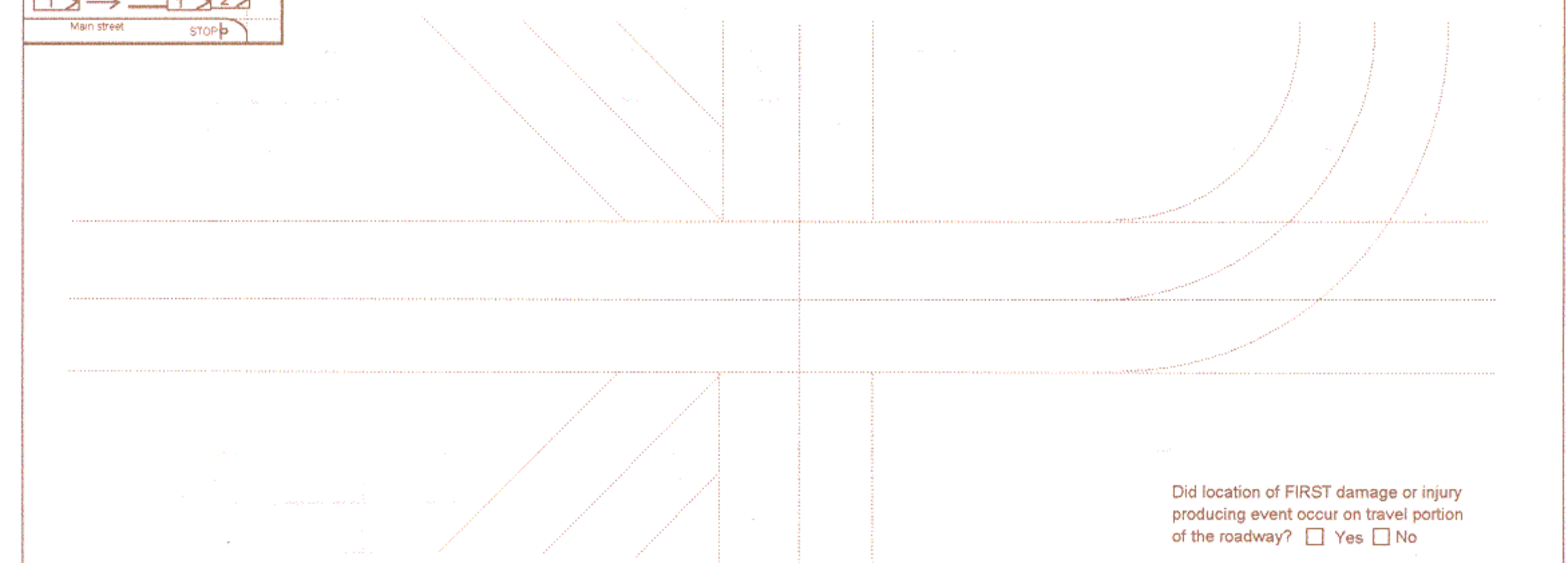
EXAMPLE:

Use these symbols in the collision diagram:

- Your Vehicle
- Other Vehicle
- Pedestrian, Animal, etc.
- STOP Sign
- Skidmarks
- Traffic Signal

Shade appropriate triangle to indicate a red traffic signal.

Defect in road/Oversize vehicle



Did location of FIRST damage or injury producing event occur on travel portion of the roadway?  Yes  No

**Remarks:** Describe the events which led to the collision.

In your opinion, what was the cause of the collision?

The Police Department is usually unable to investigate traffic collisions once the parties involved have agreed that a Police investigation is not needed, or in the event that the Slick Streets policy is in effect. If damage settlement has not been reached on the collision after six (6) months from the date of the collision, the involved parties can submit the State Operator's Collision Report Form to the Department of Public Safety. This form can be obtained at the Tulsa Police Department. The Oklahoma Department of Public Safety will then intervene to assure that settlement is reached. Your insurance company may provide further assistance.