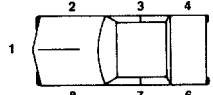
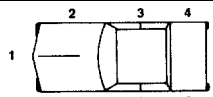
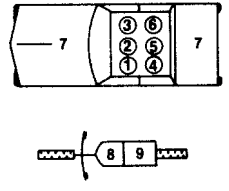


# Online Report - Traffic Crash Report

## Franklin Township Police

Local Report Number \_\_\_\_\_

Report Taken <input type="checkbox"/>	Substation <input type="checkbox"/>	Total Number of Vehicles and Pedestrians Involved _____	Combined Vehicle and Property Loss (Account for the total of all vehicles and property damaged) <input type="checkbox"/> Over \$150 <input type="checkbox"/> Under \$150													
In County Of _____	• Within the limits of Franklin County		Date of Crash M    D    Y													
Crash Occurred On _____		Within The Intersection Of _____														
If Not In Intersection _____ (List Nearest Intersecting Street, Milepost, House No.) _____ Miles    _____ Feet    W    N    E    S    Of																
<b>A</b> Unit No. _____	No. Of Occupants _____	Operating <input type="checkbox"/> Parked <input type="checkbox"/> Driverless <input type="checkbox"/> Non-Contact <input type="checkbox"/>	Insurance Co. Or Agent _____													
Driver - Pedestrian Name (Last, First, MI) _____		Address (No., Street, State, Zip Code) _____														
Phone No. _____	Birth Date M    D    Y	Age _____	Sex _____    State _____    Drivers License No. _____    Work Phone Number _____													
Owner (If Same As Driver, Write Same) _____		Address _____    Phone _____														
Veh. Year _____	Make _____	Model _____	Color _____    Style _____    State _____    License Plate No. _____    Towing Service _____    Veh/Ped Dir From _____ To _____													
Circle Damage Areas 	9 Top 10 Undercar 11 Load 12 Trailer	Damage Severity <input type="checkbox"/> Non-Functional <input type="checkbox"/> Functional <input type="checkbox"/> Disabling	Damage Scale <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy													
Vehicle Disposition <input type="checkbox"/> Driven Away <input type="checkbox"/> Remained At Scene <input type="checkbox"/> Towed		Fire <input type="checkbox"/> No Fire <input type="checkbox"/> Fire Due To Crash <input type="checkbox"/> Other Fire														
<b>B</b> Unit No. _____	No. Of Occupants _____	Operating <input type="checkbox"/> Parked <input type="checkbox"/> Driverless <input type="checkbox"/> Non-Contact <input type="checkbox"/>	Insurance Co. Or Agent _____													
Driver - Pedestrian Name (Last, First, MI) _____		Address (No., Street, State, Zip Code) _____														
Phone No. _____	Birth Date M    D    Y	Age _____	Sex _____    State _____    Drivers License No. _____    Work Phone Number _____													
Owner (If Same As Driver, Write Same) _____		Address _____    Phone _____														
Veh. Year _____	Make _____	Model _____	Color _____    Style _____    State _____    License Plate No. _____    Towing Service _____    Veh/Ped Dir From _____ To _____													
Circle Damage Areas 	9 Top 10 Undercar 11 Load 12 Trailer	Damage Severity <input type="checkbox"/> Non-Functional <input type="checkbox"/> Functional <input type="checkbox"/> Disabling	Damage Scale <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy													
Vehicle Disposition <input type="checkbox"/> Driven Away <input type="checkbox"/> Remained At Scene <input type="checkbox"/> Towed		Fire <input type="checkbox"/> No Fire <input type="checkbox"/> Fire Due To Crash <input type="checkbox"/> Other Fire														
<b>Occupant Section</b>	<b>C</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____	Position A    B    C    D    E    F											
		Address _____	Phone _____	Sex _____	 <p style="text-align: center;"><b>P-PEDESTRIAN</b></p>											
	<b>D</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____												
		Address _____	Phone _____	Sex _____												
	<b>E</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____												
		Address _____	Phone _____	Sex _____												
	<b>F</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____							Restraints A    B    C    D    E    F					
		Address _____	Phone _____	Sex _____							1 Not Used 2 None Available 3 Lap Belt Used 4 Lap/Shoulder Belt Used 5 Shoulder Belt Used 6 Child Safety Seat 7 Air Bag Used 8 Use Not Reported					
	<b>G</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____												
	Address _____	Phone _____	Sex _____													
<b>H</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____	Ejection A    B    C    D    E    F												
	Address _____	Phone _____	Sex _____	1 Not Ejected 2 Partial 3 Total 4 Trapped Inside Vehicle												
<b>I</b> From Unit No. _____	Name (Last, First, MI) _____	Birth Date M    D    Y	Age _____													
	Address _____	Phone _____	Sex _____													
Date Report Filed M    D    Y		Person That Completed Report _____														

Driver - Pedestrian - Vehicle Section

Occupant Section

