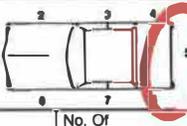
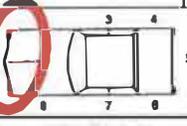


Instructions: Complete only known information. Leave blank anything that you are not sure of as an investigator may complete later.

**Local Traffic Crash Report
Franklin County Sheriff's Office**

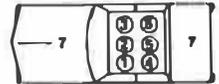
Local Report Number **Leave Blank**

Report Taken	<input checked="" type="checkbox"/> Headquarters <input type="checkbox"/> Substation	Total Number of Vehicles and Pedestrians Involved 1, 2, 3, etc.	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	Name of County	• Within corporate limits of Columbus (if not, file with correct agency)	Date of Crash M D Y
Crash Occurred On	Name of Street, Freeway, or Route		Within The Intersection Of Nearest Intersecting Street
If Not In Intersection Miles _____ Feet _____ N W E S Of (List Nearest Intersecting Street, Milepost, House No)			
A Unit No. 1	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) Driver's Name		Address (No., Street, State, Zip Code) Driver's Home Address	
Phone No. Home #	Birth Date M D Y	Age	Sex State Drivers License No. Occupation
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 Treller	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 Unit No. 2	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) Other Driver's Name		Address (No., Street, State, Zip Code) Other Driver's Home Address	
Phone No.	Birth Date M D Y	Age	Sex State Drivers License No. Occupation
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
C From Unit No.	Name (Last, First, MI) Passengers (if any) Go Here & Below	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
D From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
E From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
F From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
G From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
H From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
I From Unit No.	Name (Last, First, MI)	Birth Date M D Y	Age Position A B C D E F
	Address	Phone	Sex
Date Report Filed M D Y		Desk Officer's Name & Badge # Blank	

Driver - Pedestrian - Vehicle Section

Occupant Section

Write #'s in Box Above



P-PEDESTRIAN

Write #'s in Box Above

- Restraints**
- 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

Write #'s in Box Above

- Ejection**
- 1 Not Ejected
 - 2 Partial
 - 3 Total
 - 4 Trapped Inside Vehicle

