



**DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

# AUTOMOBILE ACCIDENT REPORT

Bureau of State Liability Claims  
 Tallahassee, FL 32399-0338

RM File #: \_\_\_\_\_

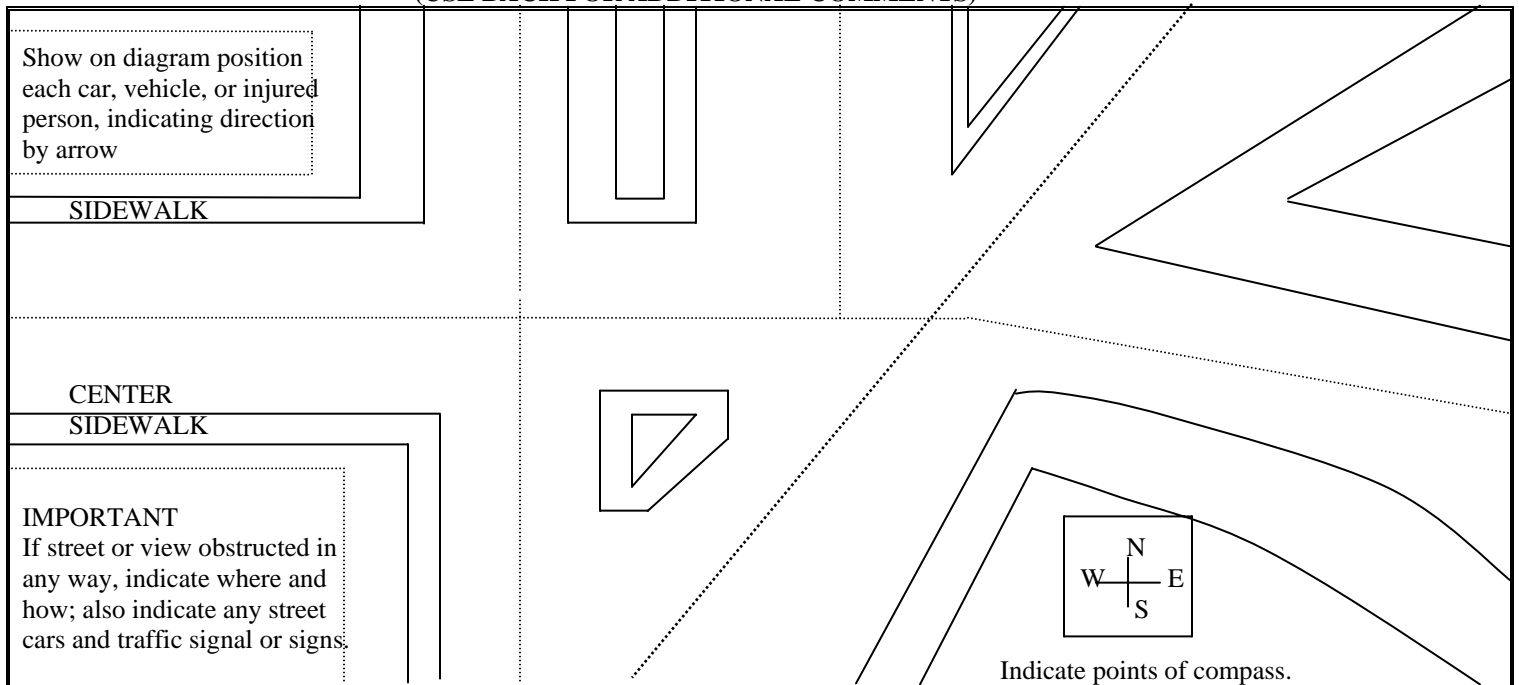
<b>INSURED STATE AGENCY</b>	Department _____ Bureau, Institution or District _____ Location and Address _____
<b>INSURED AUTO AND DRIVER</b>	Year: ____ Make: _____ Model: _____ Tag No.: _____ Driver: _____ Phone No.: _____ Employed by: _____ Age: _____ Purpose of Use at Time of Accident: _____ Amount of Damage to Vehicle: _____
<b>TIME AND PLACE</b>	Date of Accident or Loss: _____ Hour: _____ Location of Accident: _____ Police Authority Investigating: _____
<b>DAMAGE TO PROPERTY OF OTHERS</b>	Owner of Property Damage: _____ Address: _____ Phone No.: _____ Driver of Other Vehicle: _____ Address: _____ Phone No.: _____ Driver's License No.: _____ If Automobile, Year: ____ Make: _____ Model: _____ Tag No.: _____ Kind of Property and Extent of Damage: _____ Insurance Carrier: _____



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	Name:	Address	Phone No.	
<b>PERSONS INJURED</b>	1.	_____		
	2.	_____		
	3.	_____		
	4.	_____		
	Nature and extent of injuries:	1.	_____	
		2.	_____	
		3.	_____	
		4.	_____	
	If Doctor was called, give name:	Name: _____	Address: _____	
	Where was injured person taken:	_____		
By whom:	_____			

**(USE BACK FOR ADDITIONAL COMMENTS)**





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Explain fully how accident occurred:

\_\_\_\_\_

<b>Names of Witnesses</b>	<b>Address</b>	<b>Phone No.</b>	<b>State where witness was at time of accident</b>

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person Filing Report

\_\_\_\_\_  
Name of Person Taking Report

\_\_\_\_\_  
Telephone Number of Caller