



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

AUTOMOBILE ACCIDENT REPORT

State Liability Claims
Tallahassee, FL 32399-0338

RM File #: _____

INSURED STATE AGENCY	Department _____ Bureau, Institution or District _____ Location and Address _____
INSURED AUTO AND DRIVER	Year: _____ Make: _____ Model: _____ Tag No.: _____ Driver: _____ Phone No.: _____ Employed by: _____ Age: _____ Purpose of Use at Time of Accident: _____ Amount of Damage to Vehicle: _____
TIME AND PLACE	Date of Accident or Loss: _____ Hour: _____ Location of Accident: _____ Police Authority Investigating: _____
DAMAGE TO PROPERTY OF OTHERS	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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PERSONS INJURED	Name:	Address	Phone No.
	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)

<p>Show on diagram position each car, vehicle, or injured person, indicating direction by arrow</p>			
<p align="center">SIDEWALK</p>			
<p align="center">CENTER SIDEWALK</p>			
<p>IMPORTANT If street or view obstructed in any way, indicate where and how; also indicate any street cars and traffic signal or signs.</p>			
<p>Indicate points of compass.</p>			



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Explain fully how accident occurred:

Names of Witnesses	Address	Phone No.	State where witness was at time of accident

Date

Name of Person Filing Report

Name of Person Taking Report

Telephone Number of Caller