



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

AUTOMOBILE ACCIDENT REPORT

Bureau of State Liability Claims
 Tallahassee, FL 32399-0338

RM File #: _____

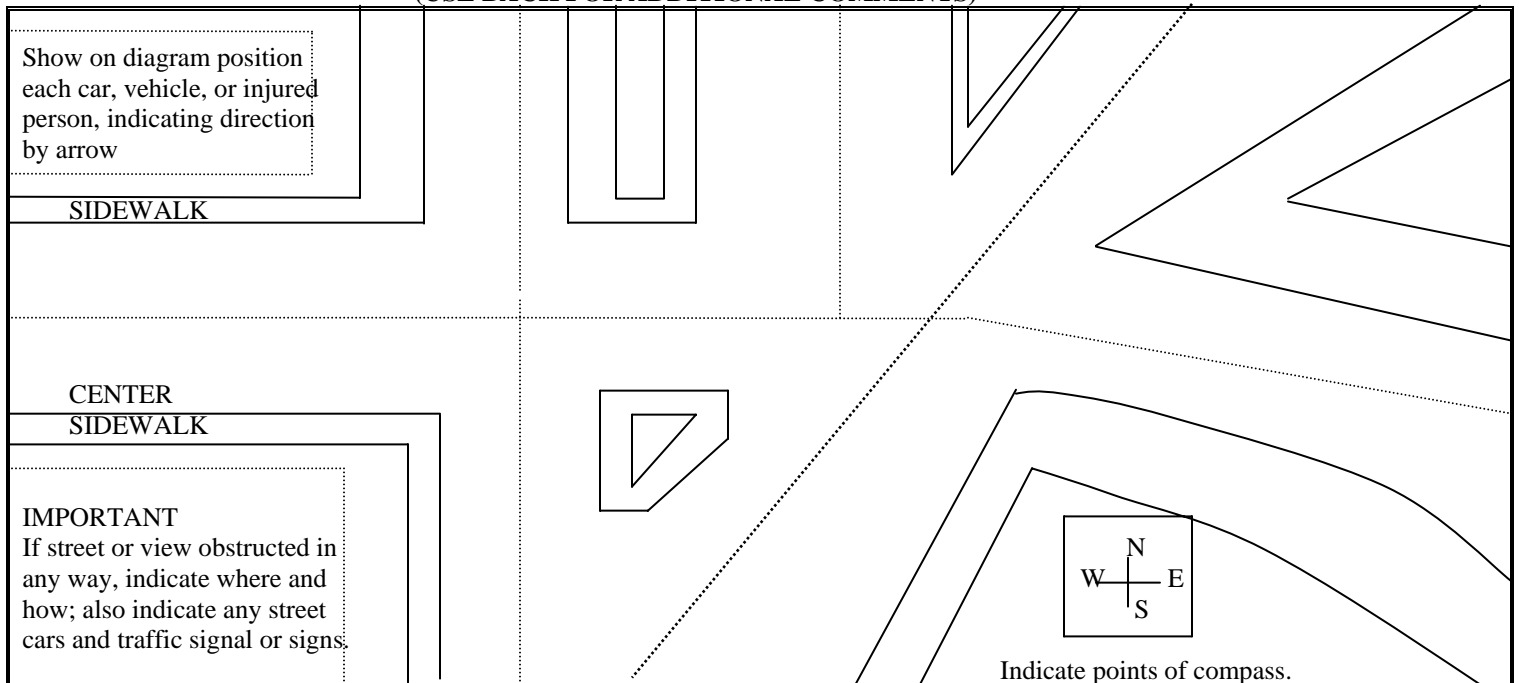
INSURED STATE AGENCY	Department _____ Bureau, Institution or District _____ Location and Address _____
INSURED AUTO AND DRIVER	Year: ____ Make: _____ Model: _____ Tag No.: _____ Driver: _____ Phone No.: _____ Employed by: _____ Age: _____ Purpose of Use at Time of Accident: _____ Amount of Damage to 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)





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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