



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

AUTOMOBILE ACCIDENT REPORT

State Liability Claims
Tallahassee, FL 32399-0338

RM File #: _____

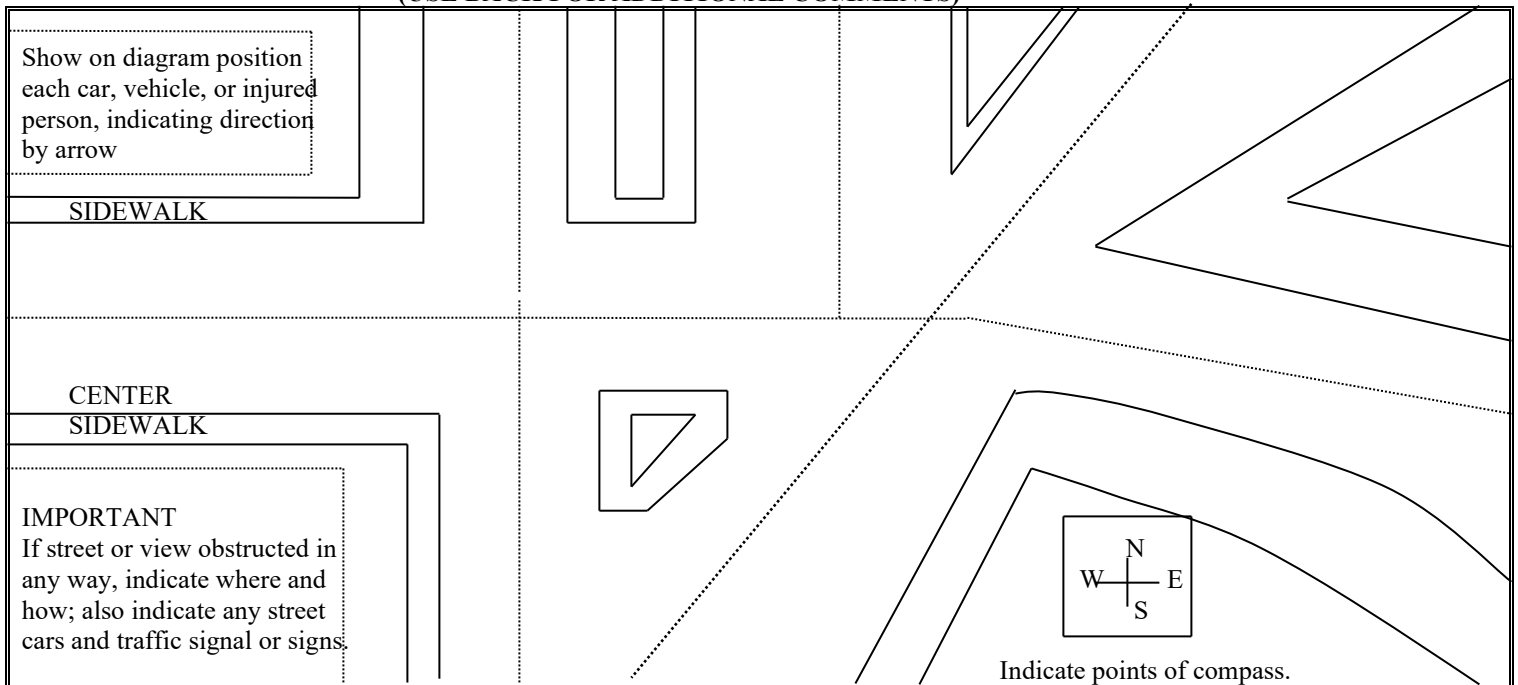
<p>INSURED STATE AGENCY</p>	<p>Department _____ Bureau, Institution or District _____ Location and Address _____</p>
<p>INSURED AUTO AND DRIVER</p>	<p>Year: ____ Make: _____ Model: _____ Tag No.: _____ Driver: _____ Phone No.: _____ Employed by: _____ Age: _____ Purpose of Use at Time of Accident: _____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



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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