



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

AUTOMOBILE ACCIDENT REPORT

State Liability Claims
 Tallahassee, FL 32399-0338

RM File #: _____

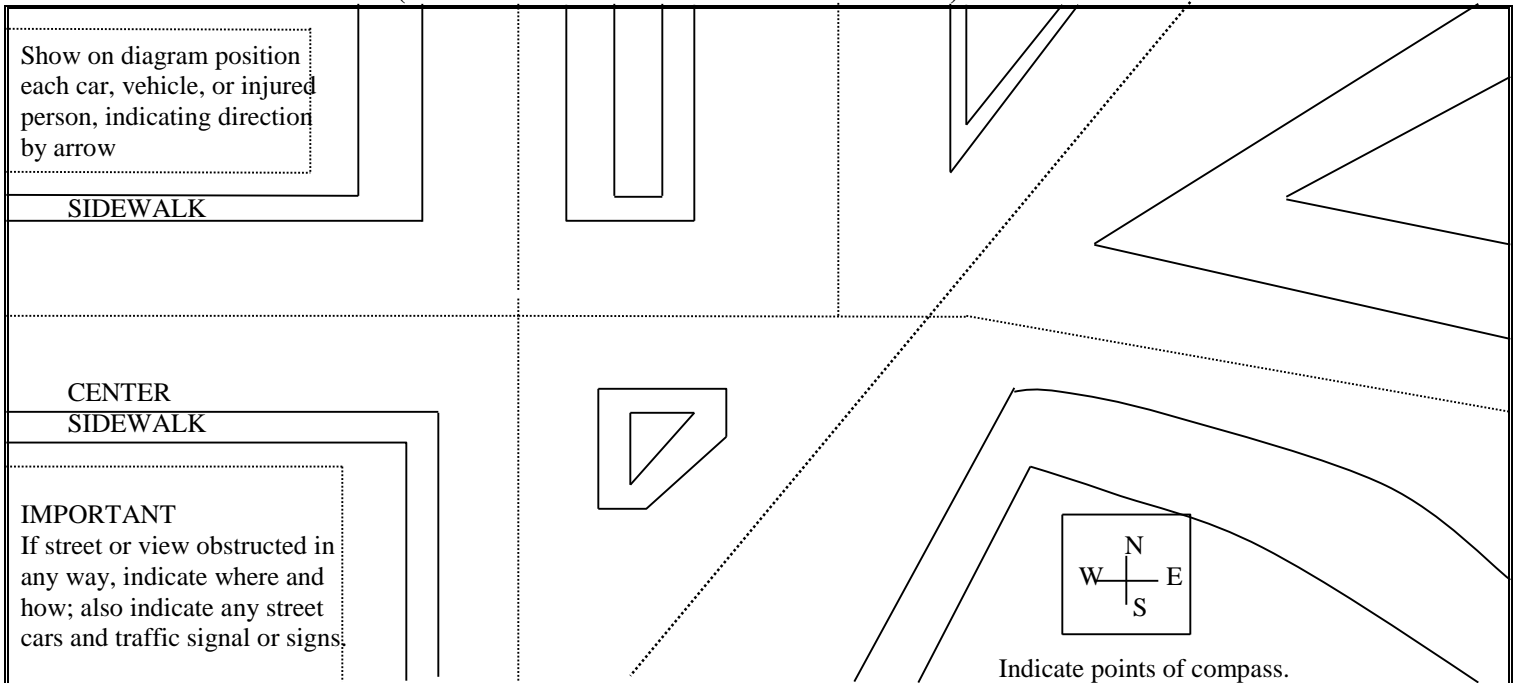
INSURED STATE AGENCY	Department _____ Bureau, Institution or District _____ Location and Address _____
INSURED AUTO AND DRIVER	Year: ____ Make: _____ Model: _____ Tag No.: _____ Driver: _____ Phone No.: _____ Employed by: _____ Age: _____ Purpose of Use at Time of Accident: _____ Amount of Damage to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