



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

CRASH REPORT

YOU MUST COMPLETE ALL SECTIONS OF THIS REPORT AND SIGN

PLEASE TYPE OR PRINT IN INK (BLUE OR BLACK)

BMV USE ONLY

The driver of a vehicle which is involved in a motor vehicle accident may file this report with the BMV within six months after the accident if both the following apply: (1) there was any personal injury or there was property damage in excess of \$400.00, and (2) the driver or owner of the other vehicle did not have insurance or other financial responsibility coverage at the time of the accident. PLEASE NOTE: Medical expenses or property damages MUST be documented and submitted with this report. Incomplete reports or forms received more than six months after the date of the accident WILL NOT be processed or returned. Please answer all questions to the best of your knowledge.

DATE OF ACCIDENT	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM	ACCIDENT LOCATION (COUNTY)	CITY
WAS A POLICE REPORT TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF VEHICLES INVOLVED	WHERE ACCIDENT OCCURRED (STREET NAME)	

1 YOUR VEHICLE INFORMATION

DRIVER NAME			
ADDRESS			
CITY	STATE	ZIP CODE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
DRIVER LICENSE NUMBER	ISSUING STATE		
TYPE OF VEHICLE	YEAR	MAKE	WAS THIS VEHICLE PARKED LEGALLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
LICENSE PLATE NUMBER	ISSUING DATE	<input type="checkbox"/> YES <input type="checkbox"/> NO	
OWNER NAME			
OWNER ADDRESS			
CITY	STATE	ZIP CODE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
DRIVE LICENSE NUMBER	ISSUING STATE		

**2 OTHER VEHICLE INVOLVED
YOU MUST PROVIDE IDENTIFIERS
WAS THIS VEHICLE INSURED? YES NO**

DRIVER NAME			
ADDRESS			
CITY	STATE	ZIP CODE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
DRIVER LICENSE NUMBER	ISSUING STATE		
TYPE OF VEHICLE	YEAR	MAKE	WAS THIS VEHICLE PARKED LEGALLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
LICENSE PLATE NUMBER	ISSUING DATE	<input type="checkbox"/> YES <input type="checkbox"/> NO	
OWNER NAME			
OWNER ADDRESS			
CITY	STATE	ZIP CODE	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
DRIVE LICENSE NUMBER	ISSUING STATE		

A INSURANCE INFORMATION

INSURANCE CLAIM OFFICE HANDLING THE CLAIM		
NAME		
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER		
INSURANCE COMPANY NAME		

POLICY NUMBER	EFFECTIVE DATES FROM _____ TO _____
NAME OF POLICY HOLDER	MUST COVER ACCIDENT DATE

YOUR INSURANCE AGENT MUST FILL OUT AND SIGN THIS SECTION

WAS THERE A LIABILITY INSURANCE POLICY IN EFFECT COVERING YOUR INSURED IF A DAMAGE CLAIM ARISES FROM THIS ACCIDENT? YES NO

AGENT SIGNATURE X	DATE
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SELF INSURED OR UNDER FLEET COVERAGE, ICC OR PUCO			
Do you operate under fleet coverage (SR-23) on file with Registrar of Motor Vehicles? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has Registrar issued a Certificate of Self-Ins.? <input type="checkbox"/> YES <input type="checkbox"/> NO	PERMIT NO.	Was your vehicle operating under authority of PUCO or ICC? <input type="checkbox"/> YES <input type="checkbox"/> NO
		PERMIT NO.	

COMPLETE REVERSE SIDE

3 OTHER VEHICLE INVOLVED				4 OTHER VEHICLE INVOLVED			
YOU MUST PROVIDE IDENTIFIERS				YOU MUST PROVIDE IDENTIFIERS			
WAS THIS VEHICLE INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO				WAS THIS VEHICLE INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DRIVER NAME				DRIVER NAME			
ADDRESS				ADDRESS			
CITY		STATE		CITY		STATE	
ZIP CODE				ZIP CODE			
DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
DRIVER LICENSE NUMBER			ISSUING STATE	DRIVER LICENSE NUMBER			ISSUING STATE
TYPE OF VEHICLE		YEAR	MAKE	TYPE OF VEHICLE		YEAR	MAKE
LICENSE PLATE NUMBER		ISSUING DATE		LICENSE PLATE NUMBER		ISSUING DATE	
WAS THIS VEHICLE PARKED LEGALLY?				WAS THIS VEHICLE PARKED LEGALLY?			
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO			
OWNER NAME				OWNER NAME			
OWNER ADDRESS				OWNER ADDRESS			
CITY		STATE		CITY		STATE	
ZIP CODE				ZIP CODE			
DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
DRIVE LICENSE NUMBER			ISSUING STATE	DRIVE LICENSE NUMBER			ISSUING STATE

IF ADDITIONAL VEHICLES INVOLVED - USE SECOND SHEET

B DAMAGE SECTION	Please document the amount of damage your property or vehicle incurred or any injury suffered by you or a passenger in your vehicle. To document your vehicle damage you MUST attach an itemized estimate of damages, attach documentation from your insurance company supporting your claim, or have a garage man verify your damages by completing this section.		
NAME OF GARAGE OR BODY SHOP		PARTS \$ _____	NOTE: Claims cannot be processed without SIGNATURE
BUSINESS ADDRESS		LABOR _____	
GARAGE MAN SIGNATURE		TAX _____	
X		TOTAL \$ _____	
PERSONAL INJURY: To document personal injury you must have a physician complete this section, or attach documentation from your insurance company supporting your claim.			
DOCTOR NAME		NAME OF INJURED PARTY <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN	
ADDRESS		ADDRESS	
DOCTOR SIGNATURE		DATE	
X			
NUMBER OF DAYS HOSPITALIZED		APPROX. AMOUNT OF MED.EXP.	
PROPERTY DAMAGE: (buildings, signs, poles, trees, shrubs, etc.): Please attach an itemized estimate of repairs, a billing, or documentation from your insurance company supporting your claim.			

AFTER COMPLETING BOTH SIDES OF THIS FORM,	
SIGN YOUR NAME	DATE
X	
Your signature and the filing of this report is an indication that the driver or owner of the other vehicle did not have insurance or other financial responsibility coverage at the time of this accident.	

MAIL COMPLETED REPORT TO: BUREAU OF MOTOR VEHICLES
ATTN: ACCIDENT REPORTS
P.O. BOX 16583
COLUMBUS, OH 43216-6583