**USE BLUE OR BLACK INK ONLY**

**Motor Vehicle Accident Report**

**IMPORTANT NOTICE**

If your accident involved an **UNINSURED MOTORIST**, please include with your report an itemized estimate of damage to your vehicle and/or property and any medical bills and/or lost wages. **DO NOT SUBMIT AN ITEMIZED ESTIMATE** if all vehicles involved in the accident are **insured**. (read below for more information)

If you were directly or indirectly involved in a motor vehicle accident, you must submit one or more of the following (if applicable) pursuant to R.I.G.L. § 31-31 “Safety Responsibility Administration – Security Following Accident”:

- If there was **damage to your vehicle** and the amount of damage is in excess of $1000.00 you must provide any and all documents to this department (i.e. itemized estimates of repair, completed and signed by the repair shop and/or a letter from an insurance company, if vehicle was totaled). Please make sure that the repair estimate includes make, model and year of the vehicle, as well as the VIN. Also include the date and location of the accident.

- If there was **damage to your property** (non-vehicle) and the amount of damage is in excess of $1000.00 you must provide any and all documents to this department (i.e. itemized estimates of repair, including materials and labor; copy of all receipts for expenses incurred to repair properly damaged, and any other documents you feel are necessary). Also include the date and location of the accident (address), and include the type of property damaged (i.e. mailbox, fence, building, etc).

- If you, as an operator, passenger or pedestrian, incurred medical expenses as a result of an injury stemming from an accident please provide an **attending physician report** detailing the description of injuries, probable period of disability, whether or not hospitalization was needed and the total estimated expenses, including fees. The Division of Motor Vehicles Accident Office also will accept alternative rehabilitative statements/bills (i.e. physical therapy).

In addition to providing an attending physician report, if you have experienced the loss of wages as a result of a motor vehicle accident you must provide verification of loss of wages from your employer which details number of hours missed, hourly rate or salary, and a calculated estimate of wages lost per time period stated. The report from your employer should contain the following information: Name, address, gender, age and occupation of injured and the employer’s name, title, address, contact phone number and signature. The Division of Motor Vehicles Accident Office will not accept this form unless it is also signed by the injured party.

**MOTOR VEHICLE ACCIDENT REPORT --- INSTRUCTIONS**

Instructions for completing the accident report:

1. Print in all areas required, except for signatures.
2. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
3. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
4. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
5. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
6. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
7. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
8. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
9. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
10. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.

**LOCATION AND TIME**

- **ACCIDENT OCCURRED ON** (PRINT NAME OF STREET OR HIGHWAY)
- **ACCIDENT OCCURRED IN** (NAME OF CITY OR TOWN)
- **IF AT INTERSECTION** (NAME OF INTERSECTING STREET OR HIGHWAY)

**OPERATOR’S NAME (FIRST, MIDDLE, INITIAL, LAST)**

**DATE OF BIRTH**

**SEX**

**OPERATOR’S LICENSE NUMBER**

**STATE**

**DIRECTION OF TRAVEL**

**RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)**

**VEHICLE OWNER (COMPLETE NAME & ADDRESS)**

**OWNER’S LICENSE NUMBER**

**VEHICLE IDENTIFICATION NUMBER (VIN)**

**VEHICLE MAKE**

**VEHICLE MODEL**

**YEAR**

**REGISTRATION CLASSIFICATION (PASSenger CAR, COMMERCIAL TRUCK, MOTORCYCLE, CAMPER, ETC.)**

**TELEPHONE**

**OTHER VEHICLE**

**DIRECTION OF TRAVEL**

**RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)**

**VEHICLE OWNER (COMPLETE NAME & ADDRESS – LINE 1)**

**DIRECTION OF TRAVEL**

**VEHICLE IDENTIFICATION NUMBER (VIN)**

**NAME & ADDRESS – LINE 2, IF NEEDED**

**VEHICLE MAKE**

**VEHICLE MODEL**

**YEAR**

**REGISTRATION CLASSIFICATION (PASSenger CAR, COMMERCIAL TRUCK, MOTORCYCLE, CAMPER, ETC.)**

**TELEPHONE**

**TOTAL VEHICLES INVOLVED**

**TOTAL INJURED INVOLVED**

**TOTAL PEDESTRIANS INVOLVED**

**HOW MANY FEET FROM NEAREST INTERSECTION?**

**IN WHAT DIRECTION?**

- **N**
- **S**
- **E**
- **W**

**FROM NAME NEAREST INTERSECTING STREET OR HIGHWAY**

rev. 03/12
### NON-VEHICLE PROPERTY DAMAGE

<table>
<thead>
<tr>
<th>STATE PROPERTY</th>
<th>CITY/TOWN PROPERTY</th>
<th>PRIVATE PROPERTY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OWNER’S ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)**

**HOME PHONE**

**CELL PHONE**

**WORK PHONE**

**DAMAGE DESCRIPTION**

---

**VEHICLE DAMAGE**

<table>
<thead>
<tr>
<th>NAME OF INJURED (FIRST, MIDDLE, INITIAL, LAST)</th>
<th>NUMBER &amp; STREET</th>
<th>CITY/TOWN</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**APPROXIMATE COST TO REPAIR YOUR VEHICLE (VEHICLE 1)** $__________

**APPROXIMATE COST TO REPAIR OTHER VEHICLE (VEHICLE 2)** $__________

**INJURED WAS RIDING IN VEHICLE # _______**

---

**INJURED**

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
<th>ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT</th>
<th>PERSON INJURED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. FATAL</td>
<td>2. BLEEDING OR BROKEN BONES</td>
</tr>
</tbody>
</table>

**NAME AND ADDRESS OF INJURED (FIRST, MIDDLE, INITIAL, LAST) | CITY/TOWN | STATE | ZIP**

---

**ACCIDENT INVOLVED COLLISION WITH ...**

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
<th>ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT</th>
<th>PERSON INJURED</th>
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</tbody>
</table>

**NAME AND ADDRESS OF INJURED (FIRST, MIDDLE, INITIAL, LAST) | CITY/TOWN | STATE | ZIP**

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**IN YOUR OWN WORDS, PLEASE DESCRIBE WHAT HAPPENED ...**

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**I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE ON THIS REPORT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**OPERATOR'S SIGNATURE (THIS REPORT MUST BE SIGNED):**

**PRINT YOUR NAME:**

**DATE:**

---

**YOUR INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>WAS YOUR VEHICLE OR THE VEHICLE YOU WERE OPERATING INSURED (LIABILITY INSURANCE) AT THE TIME OF THE ACCIDENT?</th>
<th>IF &quot;YES&quot;, COMPLETE ATTACHED FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**NAME OF YOUR INSURANCE COMPANY (NOT AGENT):**

**POLICY NUMBER:**

**POLICY EFFECTIVE DATES**

FROM: _________

TO: _________

**NAME OF POLICYHOLDER:**

**STREET ADDRESS:**

**CITY/TOWN:**

**STATE/ZIP:**
### YOUR MOTOR VEHICLE INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>VEHICLE MAKE</th>
<th>TYPE</th>
<th>YEAR</th>
<th>VIN</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF OPERATOR:</th>
<th>STREET ADDRESS:</th>
<th>CITY / TOWN:</th>
<th>STATE / ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF OWNER:</th>
<th>STREET ADDRESS:</th>
<th>CITY / TOWN:</th>
<th>STATE / ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF INSURANCE COMPANY (NOT AGENT):</th>
<th>POLICY NUMBER:</th>
<th>EFFECTIVE PERIOD:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FROM:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TO:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF POLICYHOLDER:</th>
<th>STREET ADDRESS:</th>
<th>CITY / TOWN:</th>
<th>STATE / ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF INSURANCE AGENT WHO ISSUED POLICY:</th>
<th>STREET ADDRESS:</th>
<th>CITY / TOWN:</th>
<th>STATE / ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YOUR SIGNATURE:</th>
<th>DATE SIGNED:</th>
</tr>
</thead>
</table>

### FOR USE BY INSURANCE COMPANY ONLY

RETURN THIS FORM ONLY IF NO STANDARD POLICY WAS IN EFFECT AS ALLEGED BY MOTORIST

WITH REGARD TO AN AUTOMOBILE LIABILITY INSURANCE POLICY FOR THE POLICYHOLDER NAMED ON THE REVERSE SIDE HEREOF, THE UNDERSIGNED INSURANCE COMPANY ADVISED YOU IN ACCORDANCE WITH THE ITEMS CHECKED BELOW:

1. [ ] No policy was in effect on the date of the accident.
2. [ ] Our policy for the named policyholder applies to him/her as the operator but it does not apply to the owner of the vehicle involved in the accident.
3. [ ] Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident.
4. [ ] Our policy affords bodily injury coverage only.
5. [ ] Our policy affords property damage coverage only.

**Remarks:**

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To: STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DIVISION OF MOTOR VEHICLES
600 NEW LONDON AVENUE
CRANSTON, RI 02920-3024

Name of Insurance Company

DATE: ____________________________

By: ____________________________

Authorized Representative