

DEPARTMENT OF PUBLIC SAFETY		OKLAHOMA MOTOR VEHICLE COLLISION REPORT			Submit Report if Settlement Has Not Been Made							
Please Read Instructions on Reverse Side		PO Box 11415 Oklahoma City OK 73136-0415		Driver Compliance Division		3600 N. M L King Ave Oklahoma City OK 73111						
Collision Date		Time	No. of Vehicles Involved	City		County						
Collision Location <i>(Street Name or Highway Number, Nearest Intersection)</i>												
VEHICLE NO. 1 (Your Vehicle)	Driver Name			Owner Name <input type="checkbox"/> Same As Driver								
	Date of Birth	DL No.	DL State	Date of Birth	DL No.	DL State						
	Street			Street								
	City		State	Zip	City		State	Zip				
	Vehicle Year	Vehicle Make	Vehicle Model	Vehicle Tag No.		Tag State	Tag Year					
	YOU WILL BE CONSIDERED UNINSURED AND SUBJECT TO SUSPENSION OF YOUR DRIVER LICENSE IF THE FOLLOWING SECTION IS INCOMPLETE:											
Insurance Company			Insurance Agent Name			Phone						
Policy Number:			Address									
Policy Period	From	To	City		State	Zip						
Injuries and/or Death	IMPORTANT: ATTACH ITEMIZED DOCTOR/HOSPITAL/PHARMACY BILLS (ATTACH ADDITIONAL FORMS IF NECESSARY)											
	Name		Address			Age	Sex	Driver	Passenger	Pedestrian	Injured	Killed
VEHICLE NO. 2	Driver Name			Owner Name <input type="checkbox"/> Same As Driver								
	Date of Birth	DL Number	DL State	Date of Birth	DL Number	DL State						
	Street			Street								
	City		State	Zip Code	City		State	Zip Code				
	Vehicle Make	Vehicle Year	Vehicle Type	Vehicle Tag No.		Tag State	Tag Year					
	INSURANCE INFORMATION OF OTHER DRIVER:				INSURANCE DENIAL ATTACHED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Insurance Company			Insurance Agent Name			Phone						
Policy Number:			Address									
Policy Period	From	To	City		State	Zip						
VEHICLE NO. 3	Driver Name			Owner Name <input type="checkbox"/> Same As Driver								
	Date of Birth	DL Number	DL State	Date of Birth	DL Number	DL State						
	Street			Street								
	City		State	Zip Code	City		State	Zip Code				
	Vehicle Make	Vehicle Year	Vehicle Type	Vehicle Tag No.		Tag State	License Year					
	INSURANCE INFORMATION OF OTHER DRIVER:				INSURANCE DENIAL ATTACHED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Insurance Company			Insurance Agent Name			Phone						
Policy Number:			Address									
Policy Period	From	To	City		State	Zip						
Describe what you think caused the collision. Please refer to vehicles by number:												
I STATE THAT THE INFORMATION ON THIS REPORT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE				I AM:	<input type="checkbox"/> Driver	<input type="checkbox"/> Owner	<input type="checkbox"/> Attorney/Corp./Agency Officer	<input type="checkbox"/> Insurance Agent				
				Signature			Phone		Date			



OKLAHOMA MOTOR VEHICLE COLLISION REPORT



P.O. Box 11415
Oklahoma City OK 73136-0415

Driver Compliance Division
405.425.2098

3600 N. M L King Ave
Oklahoma City OK 73111

INSURANCE INFORMATION EXCHANGE

Police Officer		DATE		Use this form to exchange your information with the other party at the scene of the collision.			
Driver Name							
Driver License No.		Date of Birth		Insurance Company		Phone	
Address		Phone		Agent Name			
City State Zip				Address			
Vehicle Owner: <input type="checkbox"/> same as driver				City State Zip			
Address		Phone		Policy No.			
City State Zip				Policy Effective Date		Policy Expiration Date	
Driver License No.		Date of Birth		Vehicle Make	Model	Year	Tag No./State

The official *Oklahoma Traffic Collision Report*, the police investigative report, can be obtained by calling Records Management at 405.425.2262

INSTRUCTIONS

WHILE AT THE SCENE OF THE COLLISION

1. Print your name and insurance information legibly in the form above.
 2. Give your information to the other driver *and* then you receive their information.
 3. Contact their insurance agent and your insurance agent to report the collision and to file the proper claim forms.
- If the insurance information provided above is denied or non-existent or you did not have the opportunity to obtain the above information, you will need to complete the reverse side of this form and submit within one year from the date of the collision.**
4. Using this form which contains the other party's information (if investigated by law enforcement personnel), complete all blanks; *incomplete reports will be returned*. Date of birth must be included for adverse driver and/or owner; your insurance information must also be included.
 5. Report must be dated and signed.
 6. Attach the following appropriate documents as evidence of personal injury or property damage.
 - (a) PERSONAL INJURY - Copies of itemized doctor, hospital, and/or pharmacy bills incurred as a result of the collision.
 - (b) VEHICLE DAMAGE - An itemized estimate of repair or total loss statement for damages caused by the collision, dated and signed by an authorized representative of a garage or body shop. Do not send any other supporting evidence such as pictures, copies of checks, or other type of documents or diskettes.
 - (c) PROPERTY DAMAGE, OTHER THAN MOTOR VEHICLE - An itemized estimate or statement of repair due to the collision separately listing the cost of materials and the cost of labor dated and signed by a qualified professional or your receipts.
 - (d) Insurance denial from other party's company if a claim was filed.
 7. Upon completion, mail the report to the Department of Public Safety at the above address.