State of Rhode Island - Division of Motor Vehicles

Motor Vehicle Accident Report

FOR DMV USE ONLY
CASE NO.

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 property 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 Office of Safety Responsibility 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 Office of Safety Responsibility 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. When multiple choices are provided, select the best choice.
4. When reporting, enter YOUR information under "YOUR VEHICLE" and the other driver's information under "OTHER VEHICLE."
5. If more than two (2) vehicles were involved, more than two (2) persons were injured or property belonging to more than one person was damaged, use an additional accident report to complete the appropriate sections.
6. Print one letter per box. Leave a blank in one box between each word. Do not use periods of commas.
7. Please remember to SIGN the accident report.
8. IF YOU ARE MAILING IN YOUR REPORT: Make sure the report is securely sealed in an envelope and mail it to the RI DMV Safety Responsibility Office at 600 New London Avenue, Cranston, RI 02920-3024.

LOCATION AND TIME

MONTH | DAY | YEAR

DAY OF WEEK: ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY

HOUR | MIN ☐ AM ☐ PM

TOTAL VEHICLES INVOLVED | TOTAL INJURED INVOLVED | TOTAL PEDESTRIANS INVOLVED

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)

IF NOT AN INTERSECTION

HOW MANY FEET FROM NEAREST INTERSECTION ?

IN WHAT DIRECTION ? ☐ N ☐ S ☐ E ☐ W FROM

NAME NEAREST INTERSECTING STREET OR HIGHWAY

YOUR VEHICLE

OPERATOR'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO DAY YEAR	SEX M ☐ F ☐	OPERATOR'S LICENSE NUMBER	STATE	DIRECTION OF TRAVEL
RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)			VEHICLE PLATE NUMBER AND STATE	TELEPHONE	☐ N
VEHICLE OWNER (COMPLETE NAME & ADDRESS)	OWNER'S LICENSE NUMBER		VEHICLE IDENTIFICATION NUMBER (VIN)		☐ S ☐ E
OWNER'S DATE OF BIRTH MO DAY YEAR	VEHICLE MAKE	VEHICLE MODEL	YEAR / REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	TELEPHONE	☐ W

OTHER VEHICLE

OPERATOR'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO DAY YEAR	SEX M ☐ F ☐	OPERATOR'S LICENSE NUMBER	STATE	DIRECTION OF TRAVEL
RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)			VEHICLE PLATE NUMBER AND STATE	TELEPHONE	☐ N
VEHICLE OWNER (COMPLETE NAME & ADDRESS – LINE 1)			VEHICLE IDENTIFICATION NUMBER (VIN)		☐ S ☐ E
(NAME & ADDRESS – LINE 2, IF NEEDED)	VEHICLE MAKE	VEHICLE MODEL	YEAR / REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	TELEPHONE	☐ W

AFTER FILLING OUT YOUR MOTOR VEHICLE INSURANCE INFORMATION BELOW, TURN OVER AND CONTINUE THE APPLICATION ON THE OTHER SIDE

DO NOT DETACH – THIS SECTION NEEDS TO REMAIN WITH THE ACCIDENT REPORT

YOUR MOTOR VEHICLE INSURANCE INFORMATION

DATE OF ACCIDENT:	PLACE OF ACCIDENT:	FOR DMV USE ONLY CASE NO.

DESCRIPTION OF VEHICLE INVOLVED IN ACCIDENT MUST CORRESPOND TO "YOUR VEHICLE" ON ACCIDENT REPORT

VEHICLE MAKE:	TYPE:	YEAR:	VIN:
NAME OF OPERATOR:	STREET ADDRESS:	CITY / TOWN:	STATE / ZIP:
NAME OF OWNER:	STREET ADDRESS:	CITY / TOWN:	STATE / ZIP:
NAME OF INSURANCE COMPANY (NOT AGENT):	POLICY NUMBER:		EFFECTIVE PERIOD: FROM: ________ TO: ________
NAME OF POLICYHOLDER:	STREET ADDRESS:	CITY / TOWN:	STATE / ZIP:
NAME OF INSURANCE AGENT WHO ISSUED POLICY:	STREET ADDRESS:	CITY / TOWN:	STATE / ZIP:
YOUR SIGNATURE:		DATE SIGNED:	

*

NON-VEHICLE PROPERTY DAMAGE

☐ STATE PROPERTY ☐ CITY/TOWN PROPERTY ☐ PRIVATE PROPERTY

OWNER'S NAME	OWNER'S ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)		
HOME PHONE	CELL PHONE	WORK PHONE	DAMAGE DESCRIPTION

VEHICLE DAMAGE

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

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

INJURED

NAME OF INJURED (FIRST, MIDDLE INITIAL, LAST) CITY/TOWN INJURED WAS RIDING IN VEHICLE # ☐

AGE ☐☐ SEX M ☐ F ☐

ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT

1 ☐ FATAL 3 ☐ BRUISES OR ABRASIONS
2 ☐ BLEEDING OR BROKEN BONES 4 ☐ COMPLAINT OF PAIN

PERSON INJURED

1 ☐ PEDESTRIAN 5 ☐ VEHICLE OPERATOR
2 ☐ PEDALCYCLIST 6 ☐ VEHICLE PASSENGER
3 ☐ PASSENGER IN BUS 7 ☐ MOTORCYCLE OPERATOR
4 ☐ OTHER 8 ☐ MOTORCYCLE PASSENGER

NAME OF INJURED (FIRST, MIDDLE INITIAL, LAST) CITY/TOWN STATE/ZIP INJURED WAS RIDING IN VEHICLE # ☐

AGE ☐☐ SEX M ☐ F ☐

ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT

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ACCIDENT CONDITIONS

ACCIDENT INVOLVED COLLISION WITH ...

1 ☐ PEDESTRIAN 4 ☐ MOVING VEHICLE 7 ☐ FIXED OBJECT 10 ☐ OTHER ______________
2 ☐ PEDALCYCLE 5 ☐ VEHICLE STOPPED IN ROAD 8 ☐ OBJECT IN ROAD
3 ☐ NO COLLISION – RAN OFF ROAD 6 ☐ PARKED MOTOR VEHICLE 9 ☐ NO COLLISION - OVERTURNED

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

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

WAS YOUR VEHICLE OR THE VEHICLE YOU WERE OPERATING INSURED (LIABILITY INSURANCE) AT THE TIME OF THE ACCIDENT? IF "YES", COMPLETE ATTACHED FORM

☐ YES ☐ NO

NAME OF YOUR INSURANCE COMPANY (NOT AGENT)	POLICY NUMBER	POLICY EFFECTIVE DATES FROM: ____________ TO: ____________	
NAME OF POLICYHOLDER	STREET ADDRESS	CITY/TOWN	STATE/ZIP

DO NOT DETACH – THIS SECTION NEEDS TO REMAIN WITH THE ACCIDENT REPORT

FOR USE BY INSURANCE COMPANY ONLY - DO NOT WRITE IN THIS AREA

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:

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

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