

OKLAHOMA MOTOR VEHICLE COLLISION REPORT <small>PO Box 11415 Oklahoma City OK 73136-0415 Driver Compliance Division 6015 N Classen Blvd Oklahoma City OK 73118</small>		Submit Report if Settlement Has Not Been Made			
SERVICE OKLAHOMA					
Please Read Instructions on Reverse Side					
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 Same As Driver		
	Date of Birth	DL No.	DL State	DL No.	
Damage Estimate	Street		Street		
	City	State	Zip	City	
Total Injury Amount:	Vehicle Year	Vehicle Make	Vehicle Model	Tag State	
	Vehicle Year	Vehicle Make	Vehicle Model	Tag State	
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		
IMPORTANT: ATTACH ITEMIZED DOCTOR/HOSPITAL/PHARMACY BILLS (ATTACH ADDITIONAL FORMS IF NECESSARY)					
Injuries and/or Death	Name	Address	Age	Sex	
	Driver	Passenger	Pedestrian	Injured	
	Killed				
VEHICLE NO. 2 Other Driver/Owner Date of Birth must be included before action can be taken under the Financial Responsibility Law	Driver Name		Owner Name Same As Driver		
	Date of Birth	DL Number	DL State	DL State	
	Street		Street		
	City	State	Zip Code	City	
	Vehicle Make	Vehicle Year	Vehicle Type	Tag State	
	Vehicle Year	Vehicle Make	Vehicle Type	Tag State	
	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 Other Driver/Owner Date of Birth must be included before action can be taken under the Financial Responsibility Law	Driver Name		Owner Name Same As Driver		
	Date of Birth	DL Number	DL State	DL State	
	Street		Street		
	City	State	Zip Code	City	
	Vehicle Make	Vehicle Year	Vehicle Type	Tag State	
	Vehicle Year	Vehicle Make	Vehicle Type	Tag State	
	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:	Driver	Owner	
		Attorney/Corp./Agency Officer	Insurance Agent		
Signature		Phone	Date		



OKLAHOMA MOTOR VEHICLE COLLISION REPORT

PO Box 11415
Oklahoma City OK 73136-0415

Driver Compliance Division
405-425-2098

6015 N Classen Blvd
Oklahoma City OK 73118

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: 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 because 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 Service Oklahoma at the above address.