Please Read Instructions on Reverse Side	DEPARTMENT OF PUBLIC SAFETY **OKLAHOMA MOTOR VEHICLE COLLISION REPORT** PO Box 11415 Oklahoma City OK 73136-0415 — Driver Compliance Division — 3600 N. M L King Ave Oklahoma City OK 73111	Submit Report if Settlement Has Not Been Made

Collision Date	Time	No. of Vehicles Involved	City	County

Collision Location

(Street Name or Highway Number, Nearest Intersection)

VEHICLE NO. 1 (Your Vehicle)

Damage Estimate

Total Injury Amount::

Driver Name			Owner Name ☐ 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

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	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? ☐ YES ☐ 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	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? ☐ YES ☐ 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

Print Form

DPS FR307 024 012008

DEPARTMENT OF PUBLIC SAFETY

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: ❑ 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 <u>you did not have the opportunity to obtain the above information</u>, 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, <u>dated and signed</u> 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.