

Alabama Department of Public Safety

Driver License Division
Safety Responsibility Unit
P.O. Box 1471
Montgomery, AL 36102-1471

For Office Use Only

DOC No.

Case No.

**COMPLETION OF THIS FORM IS REQUIRED BY §32-7-1, CODE OF ALABAMA 1975.
FAILURE TO FILE A REPORTABLE ACCIDENT ON THIS FORM MAY RESULT IN SUSPENSION OF YOUR DRIVER LICENSE.**

INFORMATION AND INSTRUCTIONS: Completion of this form is required ONLY if a motor vehicle accident occurring in Alabama caused death, personal injury, or property damage to any one owner in excess of \$250. The driver of any motor vehicle, which is in ANY MANNER involved in an accident in this state, is legally required to file a report on this form with the Department of Public Safety within thirty (30) days after the accident regardless of whether or not at fault and regardless of whether or not the vehicle involved was covered by liability insurance at the time of the accident. If such driver is physically incapable of making such report, the owner of the motor vehicle involved in such accident shall, within thirty (30) days after learning of the accident, make such report.

DATE OF ACCIDENT	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	NO. OF VEHICLES	For Office Use Only		
LOCATION OF ACCIDENT (ST./HIGHWAY)		COUNTY	Subject	Injuries	Claims

VEHICLES INVOLVED

YOUR INFORMATION (PLEASE PRINT OR TYPE)					OTHER PARTY'S INFORMATION (PLEASE PRINT OR TYPE)				
YOU ARE THE: <input type="checkbox"/> DRIVER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PROPERTY OWNER <input type="checkbox"/> OTHER					OTHER PARTY WAS: <input type="checkbox"/> DRIVER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PROPERTY OWNER <input type="checkbox"/> OTHER				
NAME (FIRST, MIDDLE, LAST)			TELEPHONE NO.		NAME (FIRST, MIDDLE, LAST)			TELEPHONE NO.	
ADDRESS: STREET NO.					ADDRESS: STREET NO.				
CITY		STATE	ZIP		CITY		STATE	ZIP	
DRIVER'S DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DRIVER LICENSE NO.		STATE	DRIVER'S DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DRIVER LICENSE NO.		STATE
NAME OF OWNER			IF SAME AS DRIVER, MARKBOX <input type="checkbox"/>		NAME OF OWNER			IF SAME AS DRIVER, MARKBOX <input type="checkbox"/>	
ADDRESS OF OWNER: STREET NO.					ADDRESS OF OWNER: STREET NO.				
CITY		STATE	ZIP		CITY		STATE	ZIP	
OWNER'S BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	OWNER'S DRIVER LICENSE NO.		STATE	OWNER'S BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	OWNER'S DRIVER LICENSE NO.		STATE
YOUR VEHICLE					OTHER VEHICLE (Use additional form if more than two [2] vehicles)				
YEAR	MAKE	TYPE	COMMERCIAL VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO	STATE	YEAR	MAKE	MODEL	TYPE	STATE
VIN			LICENSE PLATE NO-		VIN			LICENSE PLATE NO.	

PROPERTY DAMAGE

DESCRIPTION OF PROPERTY DAMAGE (OTHER THAN VEHICLE)

INJURED PERSONS (CLAIM FOR PERSONAL INJURY ON REVERSE)					INSURANCE AND/OR SECURITY				
FULL NAME OF INJURED IN YOUR VEHICLE				DID INJURED DIE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Complete the following as required by the Safety Responsibility Law of Alabama (§32-7-1 and the following sections). Mark only the appropriate box. All information will be verified.				
ADDRESS: STREET NO.					<input type="checkbox"/> 1. No liability insurance in effect at time of accident. <input type="checkbox"/> 2. Form SR-23 (fleet policy) on file with DPS. <input type="checkbox"/> 3. Your vehicle is a qualified carrier with APSC. <input type="checkbox"/> YES <input type="checkbox"/> NO APSC Certificate No. _____ <input type="checkbox"/> 4. Department of Public Safety Self-insurance Certificate No. _____ <input type="checkbox"/> 5. Motor vehicle liability policy issued by _____ (Name of insurance company, not agency)				
CITY		STATE	ZIP		POLICY NO. _____				
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	INJURED WAS: (Please circle) __ DRIVER __ PASSENGER __ PEDESTRIAN __ OTHER			POLICY PERIOD FROM _____ TO _____				
FULL NAME OF INJURED IN YOUR VEHICLE				DID INJURED DIE? <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICY HOLDER _____				
ADDRESS: STREET NO.					SIGNATURE _____ DATE _____				
CITY		STATE	ZIP						
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	INJURED WAS: (Please circle) <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> OTHER							

(Complete Reverse Side)

INFORMATION AND INSTRUCTIONS: Complete this portion of the form if you believe that another party is responsible for your damages. Do not delay filing this form because amount of damages is unknown.

PROPERTY DAMAGE

I, _____ [Full Name of Person Making Claim]
certify that damages to my property amounted to \$_____ [Amount of Damage]
as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from
_____ [Driver of Vehicle] and from
_____ [Owner(s) of Vehicle], and I have not released said party(les).
Signature of **Property Owner** _____ Date _____

INJURIES (Please complete one section for each party injured.)

I, _____ [Full Name of Person Injured]
certify that my medical expenses are \$_____ [Amount of Damage]
as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from
_____ [Driver of Vehicle] and from
_____ [Owner(s) of Vehicle], and I have not released said party(ies).
Signature of Claimant /Legal Guardian of Minor _____ Date _____

I, _____ [Full Name of Person Injured]
certify that my medical expenses are \$_____ [Amount of Damage]
as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from
_____ [Driver of Vehicle] and from
_____ [Owner(s) of Vehicle], and I have not released said party(ies).
Signature of Claimant /Legal Guardian of Minor _____ Date _____

I, _____ [Full Name of Person Injured]
certify that my medical expenses are \$_____ [Amount of Damage]
as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from
_____ [Driver of Vehicle] and from
_____ [Owner(s) of Vehicle], and I have not released said party(ies).
Signature of Claimant /Legal Guardian of Minor _____ Date _____

FORM COMPLETION REVIEW

1. Review form to ensure all blanks have been filled in.
2. Use your full, legal name.
3. Describe all property damage (Ex.: bicycle, farm equipment, house, fence, etc.).
4. Sign and date this form in spaces provided.