STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DIVISION OF MOTOR VEHICLES – ACCIDENT OFFICE
600 New London Avenue, Cranston, RI 02920-3024
Phone: 401-462-4368 www.dmv.ri.gov

USE BLUE OR BLACK INK ONLY

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 Accident Office 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 Accident Office 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, located at 600 New London Avenue, Cranston, RI 02920-3024, Attention: Accident Office

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 INITIAL, LAST)	DATE OF BIRTH MO / DAY / YEAR	SEX M ☐ F ☐	OPERATOR'S LICENSE NUMBER	STATE

RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)	VEHICLE PLATE NUMBER AND STATE	TELEPHONE

VEHICLE OWNER (COMPLETE NAME & ADDRESS)	OWNER'S LICENSE NUMBER	VEHICLE IDENTIFICATION NUMBER (VIN)

OWNER'S DATE OF BIRTH MO / DAY / YEAR	VEHICLE MAKE	VEHICLE MODEL	YEAR	REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	TELEPHONE

DIRECTION OF TRAVEL ☐ N ☐ S ☐ E ☐ W

OTHER VEHICLE

OPERATOR'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO / DAY / YEAR	SEX M ☐ F ☐	OPERATOR'S LICENSE NUMBER	STATE

RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE)	VEHICLE PLATE NUMBER AND STATE	TELEPHONE

VEHICLE OWNER (COMPLETE NAME & ADDRESS – LINE 1)	VEHICLE IDENTIFICATION NUMBER (VIN)

(NAME & ADDRESS – LINE 2, IF NEEDED)	VEHICLE MAKE	VEHICLE MODEL	YEAR	REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.)	TELEPHONE

DIRECTION OF TRAVEL ☐ N ☐ S ☐ E ☐ W

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 AND ADDRESS OF INJURED (FIRST, MIDDLE INITIAL, LAST) NUMBER & STREET CITY/TOWN STATE ZIP

INJURED WAS RIDING IN VEHICLE # _____

AGE _____ SEX M ☐ F ☐

ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT

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

PERSON INJURED

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

NAME AND ADDRESS OF INJURED (FIRST, MIDDLE INITIAL, LAST) NUMBER & STREET CITY/TOWN STATE ZIP

INJURED WAS RIDING IN VEHICLE # _____

AGE _____ SEX M ☐ F ☐

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5 ☐ VEHICLE OPERATOR
6 ☐ VEHICLE PASSENGER
7 ☐ MOTORCYCLE OPERATOR
8 ☐ MOTORCYCLE PASSENGER

ACCIDENT CONDITIONS

ACCIDENT INVOLVED COLLISION WITH ...

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

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

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:	

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