



DEPARTMENT OF LAW and RISK MANAGEMENT  
 COUNTY OF SUMMIT  
 175 S. MAIN STREET, 8<sup>th</sup> FLOOR  
 AKRON, OHIO 44308  
 330.643.8428 • FAX: 330.643.2507

# AUTOMOBILE ACCIDENT REPORT

CLAIM NUMBER
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THIS IS A CONFIDENTIAL INTERNAL DOCUMENT

CLAIMANT/EMPLOYEE LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH (YEAR/MONTH/DAY)	
HOME ADDRESS STREET			CITY/TOWN		STATE	ZIP CODE
HOME TELEPHONE NUMBER		INSURANCE COMPANY NAME/POLICY NUMBER				
INSURANCE COMPANY ADDRESS STREET			CITY/TOWN		STATE	ZIP CODE
INSURANCE COMPANY NUMBER						
MAKE OF VEHICLE	YEAR	MODEL	SERIAL NUMBER	LICENSE NUMBER/STATE		
DESCRIBE DAMAGE					ESTIMATE OF DAMAGE	
NAME OF DRIVER OF YOUR VEHICLE			AGE	DRIVER'S LICENSE NUMBER		
RESIDENCE ADDRESS STREET			CITY/TOWN		STATE	ZIP CODE
HOME TELEPHONE NUMBER						
DATE OF ACCIDENT (YEAR/MONTH/DAY)		TIME	WERE YOU WEARING A SEAT BELT?			
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/> YES <input type="checkbox"/> NO			
LOCATION OF ACCIDENT						
PURPOSE VEHICLE USED FOR AT TIME OF ACCIDENT			WEATHER CONDITION		ROAD CONDITION	
YOUR SPEED	DIRECTION		OTHER'S SPEED		DIRECTION	
POLICE INVESTIGATION BY					CHARGES	
HAD YOU TAKEN ANY ALCOHOLIC BEVERAGES OR DRUGS PRIOR TO THE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
WHO WAS RESPONSIBLE FOR THE ACCIDENT? (REASON)						
OWNER OF OTHER VEHICLE			OWNER OF OTHER VEHICLE			
HOME TELEPHONE NUMBER			HOME TELEPHONE NUMBER			
HOME ADDRESS			HOME ADDRESS			
MAKE OF VEHICLE	YEAR		MAKE OF VEHICLE		YEAR	
MODEL	LICENSE NUMBER/STATE		MODEL		LICENSE NUMBER/STATE	
NAME OF INSURANCE COMPANY			NAME OF INSURANCE COMPANY			
DESCRIPTION OF DAMAGE			DESCRIPTION OF DAMAGE			
NAME OF DRIVER	HOME TELEPHONE NUMBER		NAME OF DRIVER		HOME TELEPHONE NUMBER	
HOME ADDRESS			HOME ADDRESS			

COMPLETE BOTH FRONT AND BACK SIDES BEFORE SENDING.

